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**HEALTH
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COMPONANT**

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Abbreviations and Acronyms

ACT	Artemisinin-based Combination Therapy	IPT	Intermittent Preventive Therapy
ADEMAS	Marketing and Social Development Agency	ISM	Information System for Management
AMTSL	Active Management of the Third Stage of Labor	ITC	Information Technology for Communications
ANC	Antenatal Care	IUD	Intra Uterine Device
APL	Acceptable Performance Level	MAM	Management of Acute Malnutrition
DGS	Directorate General of Health Services	MCD	Chief District Medical Officer
DHIS	District Health Information System	MCR	Chief Regional Medical Officer
DOT	Directly Observed Treatment	MNCH	Maternal, Newborn, and Child Health
DRH	Department of Human Resources	MRB	Multi-Resistant Bacteria
DSISS	Division of the Health and Social Information System	MSAS	Ministry of Health and Social Action
DSR/SE	Department of Reproductive Health and Child Survival	NGO	Non-Governmental Organization
ECD	District Medical Team	ORS	Oral Rehydration Salts
ECR	Regional Medical Team	PAC	Post-Abortion Care
ENC	Essential Newborn Care	PAQ	Quality Improvement Partnership
EPI	Expanded Program on Immunization	PHF	Public Health Facility
FP	Family Planning	PIPE	Infection Prevention and Environmental Protection
HAS	Hydro-Alcoholic Solution	PMTCT	Prevention of Mother-to-Child Transmission
HD	Health District	PNC	Postnatal Care
HP	Health Post	PNLP	National Malaria Control Program
HSI	Health Services Improvement	PPP	Public-Private Partnership
ICP	Head Nurse	PRA	Regional Procurement Pharmacy
iHRIS	Health Workforce Information Software	RDT	Rapid Diagnostic Test
IMCI	Integrated Management of Childhood Illnesses	RED	Reach Every District
IPQS	Integrated Package of Quality Services	RSJ	Réseau Siggil Jigéen
		SA	Situational Analysis

SAMU	National Emergency Medical Service
SDP	Service Delivery Point
SEDA	Automated Data Exchange System
SFE	State Registered Midwife
SONU	Emergency Obstetric and Neonatal Care
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

I. Executive summary

The Health Services Improvement (HSI) component of the USAID health program is a five-year project that is implemented by IntraHealth International in partnership with Helen Keller International (HKI), Réseau Siggil Jigéen (RSJ), and Medic Mobile through cooperative agreement AID-685-A-11-00003. The goal of the project is to overcome major challenges in the delivery of quality health care services (accessibility, operations, health care staff, and the private sector) to support the Senegalese government's efforts to achieve the Millennium Development Goals.

The component's primary objective is to strengthen the delivery of quality health services at health facilities through the following four sub-components:

- 1) Increased access to an Integrated Package of Quality Services (IPQS)
- 2) Improved quality of health services in health posts, health centers, and regional hospitals
- 3) Improved human resources management in public sector health facilities
- 4) Development of relationships with private sector health facilities

During the third year of implementation, the component continued its efforts to increase people's access to an Integrated Package of Quality Services (IPQS), improve operations in service delivery points (SDPs), improve the performance and management of health care staff, and strengthen links between the public and private sector.

The end of Year 3 saw 80% of the country's health districts enrolled in TutoratPlus and close to half of SDPs (49%) receiving an on-site supervision visit. In these SDPs, providers' skills were strengthened, and the work environment was improved to increase people's access to quality services.

For family planning (FP), including FP services in integrated advanced strategies and in vaccination sessions had a significant effect on achieving the National FP Action Plan goals. This strategy resulted in the enrollment of 33,708 new users of FP methods in three years. The component supported monitoring of compliance with FP regulations in 95 SDPs in partnership with the district medical teams (ECDs), which helped identify corrective actions to take in the future.

To strengthen efforts in malaria control, 509 health care staff from the medical regions were updated on the new guidelines for malaria case management for the diagnosis and treatment of uncomplicated malaria and severe malaria as well as prevention and treatment of malaria during pregnancy.

Implementation of an approach combining improved intermittent-preventive-therapy-2 (IPT2) and vaccination coverage in 15 districts in the regions of Thiès and Dakar resulted in an increased IPT2 coverage rate for pregnant women, from 40% to 60% on average, and increased Penta-3 vaccination coverage for children, from 60% to 80% on average.

This year, special emphasis has been placed on infections prevention through training health care staff and setting up production units for hydro-alcoholic solution (HAS).

In the area of health care staff management, the extension and use of the Health Workforce Information Software (iHRIS) in six new regions has made health care staff availability and distribution more visible in eight regions. For the management of health information, the SEDA (Automated Data Exchange System)—a platform using mobile phones—was extended in 19 health districts after its pilot phase in Foundiougne to make health data available. These data are used by the ECDs to analyze SDP and district performance. They are also used when documenting the component's Performance Monitoring Plan, which faced major challenges in getting information due to the withholding of data.

Increasingly more relationships have been established between the public and private sector through the signing of memoranda of understanding between the health districts and private SDPs and by updating private-sector providers through training on the Integrated Package of Quality Services (IPQS). This package includes: malaria, nutrition, management of acute malnutrition (MAM), focused antenatal care (ANC), contraceptive technology, case management of diarrhea through ORS/zinc, and the Expanded Program on Immunization (EPI). Overall, 144 memoranda of understanding were signed by the end of Year 3.

II. Main achievements

Sub-component 1: Increased access to an Integrated Package of Quality Services

The component continued its efforts to make the IPQS available in SDPs in the intervention areas through TutoratPlus implementation and specific interventions in FP, maternal health, child survival, and malaria control.

1. Introduction and implementation of TutoratPlus

The component continued the TutoratPlus implementation process this year in regions with the greatest geographical coverage.

Enrollment of new health districts: TutoratPlus was implemented in 21 new health districts. Overall, 60 districts were enrolled, compared to the 51 planned for the project, or a performance rate of 118%. The number of enrolled districts amounts to about an 80% coverage rate for the country's health districts for the approach. With the exception of the Koki district in the Louga region, enrollment has been suspended for one year following changes in staff attitudes.

Situational analysis: After districts enrolled, the component supported ECDs from 21 enrolled districts to conduct a situational analysis (SA) in all 353 SDPs, including 32 private SDPs. This year, the districts conducted their SA using human resources from districts within their region that had already completed this exercise. This approach gave the regional

medical teams (ECRs) and ECDs greater ownership of the exercise. Each situational analysis is followed by a workshop to share results and to develop plans to solve problems in each district. The plan is a synthesis of all the SDP action plans for the district. Overall, since the start of the project, 1169 SDPs have conducted a situational analysis and developed plans to resolve problems identified in IPQS delivery.

Tutor training: This year, a strategy to train tutors by grouping them by package was used.

This made it possible to provide 10 training sessions in TutoratPlus to 152 tutors from all the remaining districts for enrollment; their distribution by package and by sex appears in Table 1. In addition to the tutors from the 21 newly enrolled districts, training also targeted additional tutors in districts in Kédougou region and replacements for districts where tutors can no longer continue on-site supervisions for reasons such as re-assignments or promotions.

Equipment for tutors: All tutors for package 2—family planning—received arm and pelvis mannequins and insertion/removal kits for IUDs and implants.

For package 1—pregnancy, delivery, and post-partum—22 of the package’s 73 tutors (including 42 who were trained in Year 2) were provided with mannequins for active management of the third stage of labor (AMTSL) and newborn resuscitation using the Helping Babies Breathe approach. For package-3 tutors working in disease management, most received measuring sticks and Salter scales; however, not all facilities have been equipped; 58 scales and measuring sticks were given to 25 tutors and 33 health posts.

Tutors use these mannequins and other anatomical models during coaching to strengthen providers’ skills before practicing on real cases. However, the new wave of tutors has created a shortfall in Salter scales, measuring sticks, and mannequins for AMTSL and essential newborn care (ENC). Anatomical models, scales, and measuring sticks will be purchased in Year 4 to fill this gap and ensure that tutors who need them will be ready to coach.

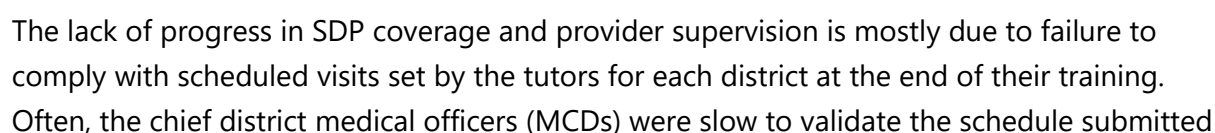
On-site supervision for providers: Providers from 426 SDPs received at least one on-site supervision visit from a tutor. The table below shows the number of staff who received on-site supervision visits.

Table 1: Distribution of trained tutors in Year 3

Service packages	Number of tutors trained		
	W	M	Total
Package 1: Pregnancy, delivery, and post-partum	31	-	31
Package 2: Family planning	24	1	25
Package 3: Disease management	7	27	34
Package 4: Management and organization of services	3	34	37
Package 5: Health information system for management			
Package 6: Health promotion	6	19	25
Total	71	81	152

Packages	Trained staff	Community-based staff	Total
Package 1: Pregnancy, delivery, and post-partum	228	124	352
Package 2: Family planning	217	169	386
Package 3: Disease management	220	260	480
Package 4: Management and organization of services	233	278	511
Package 5: Health information system for management	255	259	514
Package 6: Health promotion	243	350	593

Figure 1: On-site supervision coverage for SDPs



to them by tutors after the training, despite the suggestion that districts start supervisions within 15 days after the training. In some districts where supervisions have begun, the recommended time span between the two visits for the same tutor in the same SDP (specifically, 21 days) is frequently disregarded, which slows down the progress of SDP supervision coverage. The main reason given by MCDs is the ECDs' work overload caused by multiple demands from all levels, leaving insufficient time to devote to this activity.

Best practices learned in districts that tutors regularly visit were:

- Including tutor-visit scheduling in the districts' quarterly work plans
- Appointment by the district of a focal point in charge of TutoratPlus within the medical team to closely monitor tutor activities

The SDP enrollment rate for all packages will increase once the 152 newly-trained tutors start supervision. At the same time, work sessions will be held with districts whose on-site supervision coverage rate for SDPs is below 30% to prepare an acceleration plan for tutor visits. In keeping with the vision to improve on-site supervision coverage in SDPs, the number of tutors in the districts will be increased for districts with numerous public and private SDPs by identifying tutors who only supervise providers from private facilities to improve performance of their supervision coverage.

Orientation for ECRs/ECDs on monitoring TutoratPlus implementation: The capacities of 351 ECR and ECD members, including 40% women, from 14 regions were strengthened in tutor supervision and the use of tools for on-site supervision. Upon completing the workshop, the ECDs and ECRs said they better understood how on-site supervisions flowed and committed to validating tutor reports and supervising tutors.

Monitoring of TutoratPlus implementation by ECRs and the central level: To ensure greater ownership of TutoratPlus at the Department of Reproductive Health and Child Survival (DSR/SE) at the central level, the component held a two-day orientation on tutor supervision and on-site supervision tools with staff from the Family Planning Division of the DSR/SE.

At the regional level, the ECDs and ECRs received central-level support to monitor activities and tutor supervision in some districts, such as Passy, Koki, Popenquigne, Mbour, Thiadiaye, and Joal.

For TutoratPlus, the vast majority of SDP providers and officials state they find the approach extremely relevant. Results from supervision of implementation in a national sample of 96 sites show that 97% of providers and ECD members favor the approach and show support and commitment during on-site supervisions. The most highly appreciated aspects of TutoratPlus are:

- Strengthening of providers' skills and improvements in performance for the approach's various skills packages
- Local governments' and health committees' commitment to execute plans to resolve issues in the SDPs

- Project support in equipment for SDPs in enrolled districts through District Grants

Verification of on-site supervision reports showed the percentage of SDPs where providers have achieved the acceptable performance level (APL) of 80%. Most providers who had on-site supervision achieved the APL, as shown in Table 3 below. Generally, those who have not achieved the APL had only received one on-site tutor visit.

Table 3: Percentage of providers who achieved the APL following supervisions reported during the supervision of a sample of providers

Service package	Number of providers supervised	Percentage of providers achieving the APL
Package 1: Maternal, neonatal, and child health (ANC, PAC, AMTSL, ENC, EmONC, delivery using the partograph, kangaroo method, eclampsia, pre-eclampsia, and Basic Emergency Obstetric and Neonatal Care)	15	93
Package 2: Family planning (counselling, delivery of methods, FP-file management, preparation of RTSs*, management of FP commodities, client follow-up, ISBC**)	11	82
Package 3: Disease management (EPI, malaria, nutrition, IMCI, TB, and HIV)	13	69
Package 4: Management and organization of services, financial management, management of medicines and commodities, human resources management, use of flowcharts, preparation of job descriptions	13	85
Package 5: Management and use of health information (filling-out data collection tools, preparation of activity reports, and analysis of indicators)	11	82
Package 6: Development and implementation of IPC***, home visits, discussions, advocacy, and a plan to promote services	11	73

* Quarterly Stock Register; ** Systematic Identification of Client Needs for FP; *** Interpersonal Communication

This table summarizes the results reported during supervision of a sample of providers who received on-site supervision by tutors. This sample was representative of all regions in Senegal and was used to assess the percentage of providers who have achieved an APL.

2. Improve access to high-quality family planning services

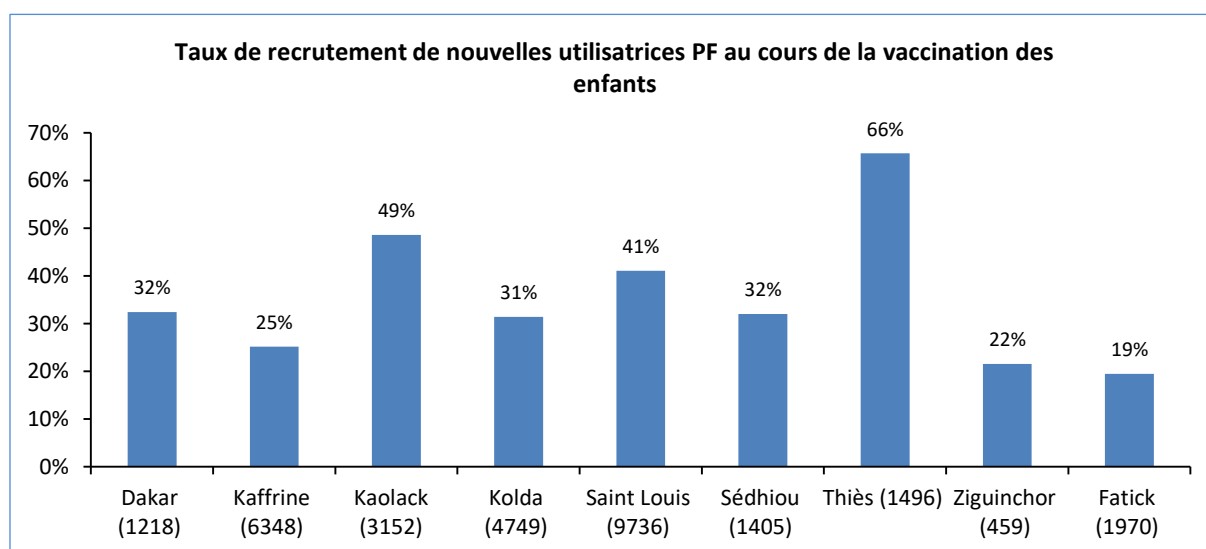
This year, the component specifically targeted enrollment strategies for new FP users in addition to strengthening trained providers' skills. These strategies were: integrating FP into high-volume services, the introduction of post-partum IUD, and support for the introduction of Sayana Press. The component also supported the DSR/SE in making FP training and monitoring/evaluation tools available.

Introduction of the post-partum IUD: In Year 3, the component partnered with the DSR/SE to develop a study protocol to introduce the post-partum IUD in the districts of Central Dakar, Guédiawaye, Pikine, West Dakar, South Dakar, Sédhiou, Touba, Bambey, Thiadiaye, and Rufisque. The protocol was submitted for approval to the Ethics Committee of the Ministry of

Health and Social Action (MSAS), which will review the protocol in October 2014. Training tools (trainer guide and participant manual) and tools for monitoring/supervision and data collection were developed and will be validated during a workshop for all stakeholders. Once the Ethics Committee has approved the protocol, training can begin for providers in the intervention SDPs.

Inclusion of FP services in high-volume services delivery: The component continued to integrate FP services into vaccination services and during advanced strategies that were implemented in the health huts by the health posts. During this year, 1160 information sessions were conducted during vaccination, and 33,060 people (including 2527 men and 30,533 women) were exposed to FP messages. These sessions helped enroll 10,905 new users of an FP method, or an overall enrollment rate of 35%, which varied greatly from one region to another, as seen in Figure 2. Annex 4 summarizes the number of new users enrolled by strategy and shows that injectables are used most frequently, with 57% of women choosing them.

Figure 2: Enrollment rate for new FP users during vaccination of children among sensitized women, October 2013–September 2014



The intervention was implemented in the Diourbel region in some high-volume health centers and health posts. However, data collected using the system's tools cannot disaggregate the enrollment of FP users by intervention. Corrective measures will be applied next year so that SDPs and districts will use a reporting format that covers integration of FP in vaccination services.

Alongside the information sessions, advanced strategies implemented in health huts by health posts also led to the enrollment of 6453 new users of FP methods. This brings the number of new enrolled users through integrated services to 17,417 for the year.

Thus, three years of implementation has enabled the component to enroll 33,708 new users of FP methods, or 24.97% of the National Action Plan for an FP target of 135,000 new users enrolled in public SDPs.

Support for the districts and regions to implement the FP action plan: The component also supported the medical regions of Kolda and Saint Louis to implement their regional plans to promote FP. The medical region of Kolda received technical and financial support to train 57 providers (70% women) in FP-file management. This training targeted 43 SDPs, including 1 private SDP, 2 health centers, and 40 health posts. The Saint Louis medical region, in partnership with the Saint Louis regional unit of the National Midwives Association, organized Reproductive Health/Family Planning Days to raise awareness and deliver these services. Overall, 499 consultations were conducted, and 30 new users of FP methods were enrolled. This training enabled the relevant medical regions to include these achievements when implementing their regional FP plan.

Revision of FP training and monitoring tools that include contraceptive methods newly introduced into the range of contraceptives: With component support, the DSR/SE held a workshop to revise the provider training manual on contraceptive technology. The revised manual covers contraceptive methods that have been newly introduced into the range of products, i.e., Implanon and Sayana Press. Once approved, the manual will be shared with ECRs and ECDs and schools for basic health training (the National School of Health and Social Development and the regional training center).

Support to implement the plan to introduce Sayana Press: The component participated in meetings to introduce Sayana Press, organized by the DSR/SE and USAID in partnership with PATH. These meetings helped define synergies with both the Community Health and Health Communication and Promotion components as part implementing the contract signed between PATH and IntraHealth to train providers on Sayana Press.

During this year, FP services delivery improved in SDPs through on-site training with TutoratPlus with at least 386 providers (including 242 women) making visits for the FP services package. For example, in the Médina Daffé health post in Diouloulou district, the user rate for FP methods nearly doubled following on-site supervision of the head nurse (ICP) for the FP package ([See case study in Annex 8](#)).

3. Increased availability of quality maternal and neonatal health services

This year, the component worked with the DSR/SE to improve maternal, newborn, and child health (MNCH) services, emphasizing emergency obstetric and neonatal care (EmONC), focused ANC, and post-abortion care (PAC).

Strengthening EmONC: The DSR/SE now has an EmONC training module for providers and a pool of three trainers in each region for decentralized EmONC training of providers using a standardized approach through technical and financial support from the component.

Management of pregnancy: To improve the management of pregnancy in SDPs in IPQS regions (except for the Louga region), 333 providers (71% women) from 230 SDPs received capacity building on focused ANC, which emphasizes screening and treating complications of pregnancy and interpersonal communication.

Through TutoratPlus implementation, 352 providers (including 260 women) received on-site supervision for the pregnancy, delivery, and post-partum package. Supervision results clearly showed that on-site supervision has improved the delivery of maternal and neonatal health services. For example, in the Dougar health post in Diamniadio district, the ICP stated, "Since TutoratPlus, I provide prenatal consultations and deliveries; until the tutor came, I thought these services were exclusively assigned to midwives." Thus in the three months following her on-site training, she performed 10 deliveries applying AMTSL, which she had not done at all before.

Post-abortion care: With health care staff turnover in SDPs, the component trained 57 providers (79% women) on PAC. This training helped ensure PAC continuity and availability, based on standards and protocols in 24 SDPs, including 14 health centers, 6 hospitals, 3 health posts, and 1 private health post in the regions of Sédhiou, Kaolack, Kolda, and Diourbel.

4. Strengthening the management of child health and nutrition

The component mainly supported the Division of Food and Nutrition and the Division of Child Survival to implement their annual work plan.

Management of diarrhea with ORS/zinc: The component scaled up case management of diarrhea with ORS/zinc by training 247 health care workers (including 188 women) from the South, North, and Central Dakar districts.

Management of Malnutrition: The regions of Dakar and Kaolack have 288 providers (111 men and 177 women) trained in the management of acute, moderate, and severe malnutrition with or without medical complications. Training covered 149 SDPs, including 133 public, 11 private, and 5 semi-public SDPs. In the Sédhiou and Kédougou regions where acute malnutrition is still prevalent, the component strengthened the capacities of 58 providers (45 men and 13 women) from 51 SDPs (health posts, nutrition recovery and education units, and nutrition recovery and education centers) to use the WHO Anthro software for improved growth monitoring and screening for acute malnutrition.

Support for the implementation of the National Child Survival Plan: As part of implementing the National Child Survival Plan, the medical regions of Fatick, Dakar, Kaffrine, Kaolack, Diourbel, and Thiès received support for conventional training for 170 providers (including 88 women) on integrated management of childhood illnesses (IMCI). This support was provided following a request from the DSR/SE, which had identified gaps.

Also, 320 providers (including 216 women) received on-site supervision for nutrition applied to the life cycle and IMCI through TutoratPlus.

5. Malaria control

In Year 3, the component focused its malaria control efforts around strengthening providers' capacities, implementing the approach to improve IPT2, applying end-use verification of antimalarial inputs, and disseminating new guidelines for malaria prevention and treatment.

Training/Refresher training on malaria prevention and treatment: With component support, the districts organized training sessions for providers that included new policies for care. These providers will be able to treat malaria cases using the National Malaria Control Program (PNLP) recommendations, particularly for intermittent therapy and the introduction of Artemisinin-based combination therapy (ACT) for pregnant women. Thus, 540 providers (including 309 women) of the set 309 target were trained, resulting in a 175% performance rate, mainly through training providers from the Louga region. The chief regional medical officer (MCR) of Louga requested that the region's providers be updated on the new guidelines for malaria management.

Implementation of approaches to improve IPT2 adherence: After implementation was evaluated in the two pilot districts of Mbao and Touba, the approaches were extended in the five remaining suburban districts and the nine districts of Thiès. IPT2 coverage improved in 15 districts in Dakar and Thiès, resulting in a rise in the average rate from 30% in 2013 to 60% in the first half of 2014 due to the approach to improve IPT.

Support for the districts consisted of conducting a situational analysis of IPT, developing plans to restart IPT, advocacy among local governments for greater availability of Sulfadoxine-Pyrimethamine, and strengthening communication with communities in partnership with the Community Health component.

Specifically, the approach involves these activities:

- An information and advocacy meeting with local officials of intervention districts
- Review of data on IPT2
- Situational analysis of IPT2 in health posts and health centers
- Meeting to share results from the situational analysis
- Development of a plan for corrective actions
- Implementation of the plan by:
 - Retraining trained staff
 - Training 130 community-based staff from SDPs on the prevention, diagnosis, and treatment of malaria
 - Organizing a caravan to raise awareness on IPT2
 - Monitoring the implementation of identified activities

End-use verification of antimalarial inputs: Verification was implemented in the central (Kaolack, Fatick, Kaffrine, and Diourbel), western (Dakar and Thiès), and northern (Matam and Saint Louis) areas of Senegal. This activity established a baseline of the situation at the visited warehouses, particularly in terms of antimalarial commodity availability, and set up a plan for corrective measures before the rainy season to decrease mortality and morbidity caused by malaria. It also helped to correct some gaps on site in managing commodities.

Recommendations were made for the medical regions and health districts, particularly on the need to comply with the set frequency of supervisions in the health pyramid, sanctioned by

plans to resolve issues, which are monitored by the upper level. The supervision team also stressed the need to train ECDs and ICPs and to ensure SDPs prepare a monthly stock report to send to the next level. This report should be shared in coordination meetings to heighten the visibility of the management of essential medicines, in general, and antimalarial commodities, in particular. Supervision found that 27% of sites had an ACT stockout during the last three months.

Sharing study results on the flowchart: The component supported the PNLP to hold a workshop to share results from the evaluation study of the flowchart to diagnose uncomplicated malaria. The study sought to assess the flowchart's sensitivity, specificity, and predictive values when used in real conditions and its acceptability among providers who use it when treating uncomplicated malaria. Workshop participants recommended that the PNLP discuss applying the flowchart depending on the time of year, patient age, and other characteristics by weighing the option outlined in the MSAS national policy that seeks to shift from controlling malaria as an endemic disease to pre-elimination.

This study highlighted limitations in the flowchart's validity and recommends the systematic use of rapid diagnostic tests (RDTs) for all patients with fever or a history of fever, especially in a context of pre-elimination of malaria.

Finalization and dissemination of the document on the new guidelines for malaria management: In addition to provider training on the management of malaria mentioned above, the component supported the PNLP to disseminate the new treatment guidelines. Overall, 777 providers, including 483 women, attended these orientations, which were highly anticipated in the health districts (demand was high given the outcomes). This allowed health districts to ensure all public and private practitioners had the same information for treating patients with malaria, including pregnant women.

6. HIV and tuberculosis control

The component supported training for 28 providers (61% women) in the Kédougou district as part of the implementation of activities in their plan to eliminate mother-to-child transmission. This training helped the district strengthen capacities for its health workers in the prevention of mother-to-child transmission (PMTCT) and introduce them to polymerase chain reaction techniques to screen newborns and infants for early-stage maternal HIV transmission. The technical team used the opportunity to strengthen providers' capacities in the integrated management of adult and adolescent illness in the context of HIV control. These sessions were held jointly with the Division of AIDS/STI Control.

Supervision conducted to monitor component implementation revealed that 90% of SDPs provide HIV testing services. This demonstrates good availability of PMTCT services in SDPs.

7. Improved vaccination services

The component conducted these activities this year:

Training for providers on the new Expanded Program on Immunization guide in all regions in Senegal: Training enabled providers to upgrade the management of vaccines and the cold chain, the safety of injections, waste management, integrated surveillance of diseases, and response to epidemics. They also learned about new vaccines introduced in October 2013 for pneumococcus and in 2014 for rubella and the second dose for measles. Overall, 1001 providers were trained, or an achievement rate of 200% for the annual goal. The overrun occurred because it was imperative that the new guide be disseminated quickly to all providers.

Introduction of the pneumococcus and rubella vaccines: The Department of Medical Prevention received component support to hold a preparatory workshop for technical, communications, surveillance, and logistics committees. Management tools and planning for activities to introduce the pneumococcus vaccine were finalized during the November 2013 meeting.

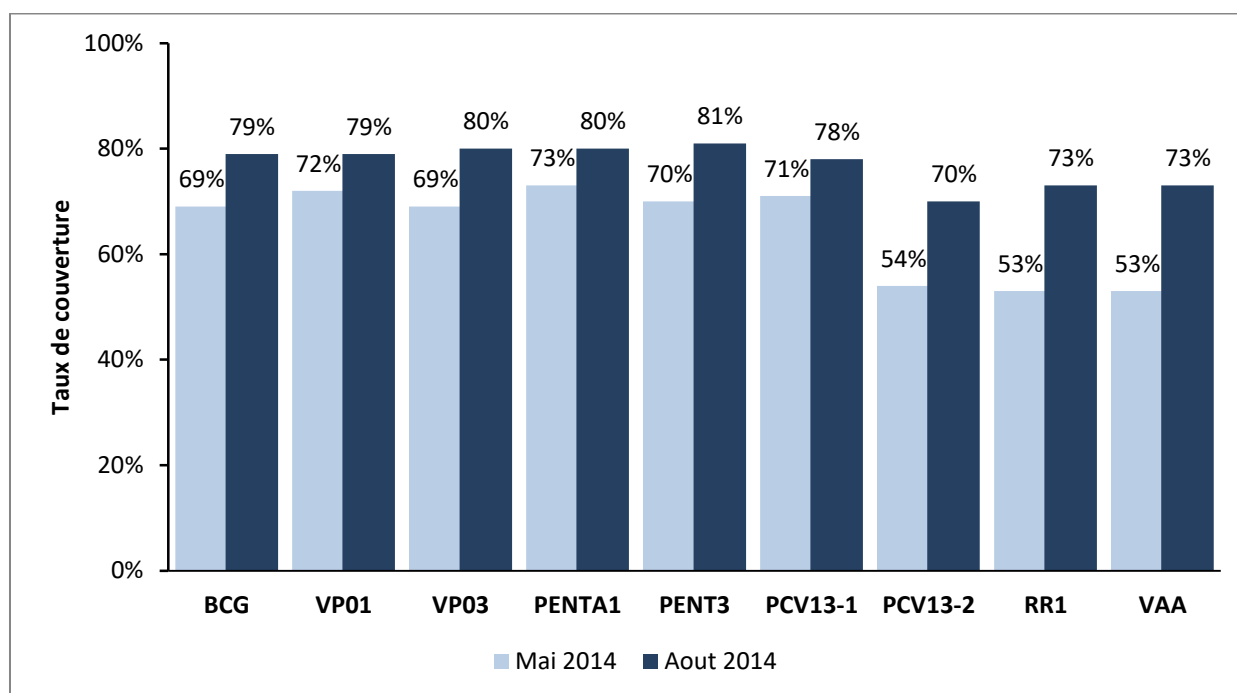
National supervision of the measles rubella campaign: The component supported the Department of Medical Prevention to supervise catch-up vaccinations for children who are not covered. Results were good, with a coverage rate ranging from 96% to 108% for the target population of 9 months–14 years.

Implementation of the Reach Every District approach in 15 districts: This support consisted of sharing recovery plans with all stakeholders; these included community networks (Bajenu Gox and CHWs *relais*), mutual health organizations, local and administrative officials (prefects, Rural Council presidents, and mayors), the ECD, the ECR, and heads of SDPs. The Reach Every District (RED) approach was implemented in 150 SDPs, including 4 private SDPs. Also, catch-up days for the routine Expanded Program on Immunization (EPI) were held in Mbour and Thiès districts as part of implementing the RED approach. This caught children who were not covered for all antigens. Component support to implement plans to restart EPI had a significant impact on raising Penta 3 vaccination coverage in the intervention districts, which went from 60% to 80%, on average.

Printing of new tools for EPI management: The component supported the printing of tools to introduce the second dose of measles vaccine. The following tools were reproduced: 500 vaccine stock movement registers, 920 order delivery books, 1500 monthly stock reports, 1500 daily collation tables, and 200,000 immunization cards to improve the availability of management tools for the second measles/rubella vaccine reminder.

Overall, immunization coverage reported a change from May 2014 to August 2014 for all antigens, as shown in the figure below. Penta 3 had the highest coverage after significant efforts using the RED approach in low performing districts.

Figure 3: Change in immunization coverage in 2014



8. Institutional support for partners

As part of the inter-agency joint direct funding mechanism, six medical regions—Thiès, Kolda, Kaolack, Diourbel, Sédhiou, and Ziguinchor—received component support for a total of 101,244,073 FCFA in 2014.

Also, the component supported 38 sub-recipient districts through District Grants for a total of 175,248,336 FCFA. This grant allowed them to implement these key activities: training for health committees on their roles and responsibilities, quarterly and mid-year reviews of TutoratPlus, the signing of memoranda of understanding between districts and private health facilities, and providing health posts with supplies.

The health committees are expected to partner with health facility staff to co-manage resources, but most have never been trained. This explains the numerous shortcomings within these facilities. All the health committees for the 38 sub-recipients have been trained on their roles and responsibilities. Training led to the re-establishment of several health committees slated for renewal. Training has also helped the health committees to understand the legislation and decrees governing them and to fully grasp their roles and responsibilities so they can better manage community health.

Each of the 38 sub-recipient districts conducted at least one quarterly review of TutoratPlus implementation, and 7 districts conducted a second one. The quarterly reviews allowed districts to discuss the situation and results of the TutoratPlus approach with all stakeholders,

to monitor the involvement of private health facilities, to analyze problems, and to identify corrective actions.

To date, 21 districts have completed at least one of the TutoratPlus mid-year reviews. This review aims to: (1) share achievements of TutoratPlus implementation, including the use of the IPQS, with all stakeholders; (2) monitor the execution of memoranda of understanding between the district and the private SDPs; and (3) identify mechanisms for sustaining the TutoratPlus approach. The TutoratPlus quarterly and mid-year reports served as a platform to discuss TutoratPlus accomplishments and successes and to resolve issues around the effective participation of all stakeholders, namely district medical teams, health committees, local governments, tutors, and private health facilities.

The difference noted in the number of reviews conducted is primarily due to delays in completing milestone 1, concerning validation of the action plan, signing the MOUs with private health facilities, and validation of the supply list.

Sub-component 2: Improved quality of health services in health posts, health centers, and regional hospitals

1. Support for equipment and supplies for SDPs

The component supported the 38 TutoratPlus districts to obtain supplies and equipment through sub-grants. Supplies were purchased based on needs identified during the situational analysis and will help improve the quality of services at the SDP level.

In addition, 225 implant insertion/removal kits and 225 IUD insertion/removal kits were provided to SDPs in the IPQS regions, and 76 SDPs received measuring sticks and scales ([See Annex 6](#)).

2. Securing products for contraception, reproductive health, child survival, and malaria

For Year 3 of the project, the component continued to support the MSAS to increase the availability of essential tracer drugs and commodities. For this, the component:

- Continued to support the DSR/SE to hold two workshops to plan for USAID- and UNFPA-funded contraceptive needs for Senegal to achieve a 27% contraceptive prevalence rate by 2015
- Continued support for medical regions in partnership with the DSR/SE and the National Procurement Pharmacy for logistics supervision of 11 regional procurement pharmacies (PRAs), 76 district warehouses, 7 regional hospitals, 5 type-1 public health facilities (PHFs-1), and 74 health center warehouses, reaching 70 women and 90 men
- Started support for districts to decentralize management of contraceptives by piloting an approach to eliminate medicine stockouts in Nioro before extending it to three other districts, reaching 75 SDPs (see Annex 6)

Overall, although improvements have been noted in contraceptives and essential medicines availability at the SDP level, supervision of implementation by the component has revealed persistent stockouts. Oral contraceptives had the fewest stockouts (18% of SDPs), while a magnesium sulfate stockout occurred in 40% of SDPs (see table below).

Corrective actions involved developing a plan to resolve issues, focused on:

- Strengthening of distributors' capacities
- Advocacy for greater ICP involvement in drug management and ECD member involvement in monitoring recommendations made during supervisions.

Table 4: Stockouts of essential commodities and medicines over recent months this year (N=95), from July to September 2014.

Medicine	% of SDPs that had a stockout
ACT	27
Sulfadoxine-Pyrimethamine	21
Oral contraceptive	18
Magnesium sulfate	40

3. Strengthening the referral and counter-referral system

As part of controlling maternal, neonatal, and child mortality, the component supported the SAMU (National Emergency Medical Service) to implement a pilot project to decentralize referrals/counter-referrals between the districts and health posts in Thiès. Decentralization aims to improve early care for obstetric and pediatric emergencies during mobile team visits into the field. Following the actual start of decentralization, the mobile team made several visits to provide care to 34 patients (16 women and 18 men) from 10 local communities. Among these 34 patients, 6 were treated for obstetric emergencies. For example, Mrs. K.S., age 25, was evacuated from the Diourbel hospital to the resuscitation unit in Pikine hospital for severe eclampsia and hemorrhage; Mrs. Nd. A.D., age 25, was evacuated from the Tivaouane hospital to the resuscitation unit in Pikine hospital for severe eclampsia, coma, and hemolysis elevated liver enzymes low platelet count syndrome.

During Year 3, the component supported the SAMU to train health staff on managing emergencies. The participants were from the regions of Kolda, Sédhiou, Dakar, and Ziguinchor and play a role in managing emergencies (doctors, pharmacists, midwives, and ICPs). Table 5 shows the number of staff who were trained, by region.

Table 5: Training of health staff on managing emergencies

	Men	Women	Total
Thiès	17	20	37
Ziguinchor	33	19	52
Kolda	29	16	45
Sédhiou	22	22	44
Dakar	8	8	16
Total	109	85	194

Training ensured that: protocols for emergency care through SAMU were disseminated to providers, coverage was better and more extensive, conditions for treating emergencies were improved, and referral/counter-referral was applied properly.

Training sessions resulted in several recommendations for improving referrals/counter-referrals in the regions: Primary among these recommendations was training all ICPs and midwives in treating emergencies and providing all SDPs with emergency kits.

However, the pace for training providers on treating emergencies is relatively slow, due to the difficulties in setting dates with the relevant regions to roll-out the activity. After training, the challenge will be getting the medical regions and health districts to apply and monitor these recommendations.

With component support, the SAMU conducted post-training follow-up for providers from the Ziguinchor region. Supervisors from the SAMU team visited the ECR, the ECD of Bignona (health center and health posts), the regional hospital, and the Regional Procurement Pharmacy (PRA). Post-training follow-up aimed to assess achievements for decentralized training of ICPs at the district level, the implementation of emergency kits at each SDP, providers' capacities on managing emergencies, and the availability of emergency commodities through the PRA. The following were noted after these visits:

- Strengths: Best practices in handling emergencies for staff who have already been trained, existing treatment protocols, resources for treatment (kits and emergency transport donkey carts), and drug availability at the PRA level.
- Areas for improvement: Lack of mastery in handling emergencies among some new staff. By contrast, for all supervised staff, we noted a lack of emergency kits at the health centers and health posts due to lack of earmarked budget and no orders for some commodities that remained in storage until expiration because staff were unaware of their availability.

Following training on managing emergencies, the SAMU, with component support, conducted a specialists tour at the regional hospitals of Kolda and Sédhiou. They visited the emergency unit, operating room, maternity ward, pediatrics unit, surgery unit, and radiology unit. After the specialists tour, recommendations were made to improve patient care. One recommendation was to set up newborn corners inside the operating room and to ensure to the extent possible that a pediatrician is present during cesarean sections; another sought to provide emergency kits to pediatrics and the emergency unit.

4. Implementation of integrated advanced strategies

As part of improving the accessibility and availability of quality services at the community level, the component supported advanced strategies for vaccination for all regions in Senegal. This involved having the ICP/State registered midwife (SFE) or a qualified staff member appointed by the health district provide a minimum package of services at the health hut level in the area covered by the Community Health component. Advanced strategies were held every two months by the health post or health centers and were

combined with supervision of health huts with the participation of the health hut's midwife. Overall, 243 SDPs conducted 1945 advanced strategies implemented in 1388 health huts. Among these huts, 626 were supervised. The table in [Annex 5](#) provides an overview of services delivered through these advanced strategies.

5. Quality improvement partnership for SDP services, including client flow

Implementation of the Quality Improvement Partnerships (PAQ) approach saw several achievements, including continuation of the PAQ tutor visits to SDPs in Year 2; training for tutors and district focal points for Year 3 and the start of tutor visits for Year 3; monitoring of action plans; joint supervision; and the annual assessment workshop.

PAQ implementation in SDPs: This year PAQ tutors visited 320 SDPs, including 70 newly enrolled SDPs. The visits resulted in setting up the PAQ teams and PAQ committees and the developing SDP action plans to improve the quality of services. The number of SDPs covered is 581.

Training for PAQ tutors: Training sessions for tutors on the PAQ in Year 3 took place in April and May 2014 in Kaolack, Ziguinchor, Saint Louis, and Thiès. All sessions were preceded by a session for trainers and the RSJ executive team to discuss training tools. The goal was to divide up responsibilities between trainers, do role plays, and gauge impressions from the regional focal points on project implementation.

Coordinators for the USAID health program, MCRs, MCDs, and regional program managers have boosted their presence at opening ceremonies and shown their commitment to the project, which involves the community, providers, and officials in improving the quality of health services. Overall, 46 tutors, including 24 women and 22 men, were trained. As for the district focal points, 23 received orientation during the four sessions. The sessions mainly dealt with presenting the HSI program, the PAQ approach, and the steps for implementation, namely: seeking support, establishing the perception of quality, holding a meeting to ensure mutual understanding, and implementing and evaluating the approach.

Monitoring of PAQ implementation: Support teams from the districts of Kaffrine, Passy, and Fatick conducted missions to monitor action plans. Three IntraHealth/RSJ joint supervision missions were conducted this year in districts in the regions of Saint Louis, Louga, Kaolack, Kaffrine, Fatick, Diourbel, Dakar, and Thiès. These missions helped determine progress made in PAQ implementation and the extent of stakeholder buy-in.

Those interviewed praised PAQ implementation, which has helped resolve issues identified in the teams' action plans. Highlighted issues are:

- Recruitment of trained staff (SFEs and nurses) by local governments and health committees at the SDPs of Thiamène, Tessekere, Mbaye Awa, and Ndiaye Wolof
- Purchase of equipment and supplies such as a back-up generator (Darou Marnane SDP), solar battery (Bicole and Gui Dakhar SDPs), and gowns for staff (Thiago SDP)
- Purchase of an ambulance by local governments (Diossong and Diouroup)
- Construction/renovation of structures (Touba Darou Kaira, Ndindi, and Keur Mbouki)

- Water supply through borehole management associations
- Better communication between the various actors
- Human investment activities (clean-up, backfilling)
- Involvement of local governments and health committees to execute plans for awareness-raising activities
- Inclusion the PAQ as an agenda item during some district-level coordination meetings

In addition, the network held a workshop to assess the activities' achievements, attended by all regional focal points, the IntraHealth team, the RSJ executive team, and administrative board members. The workshop accomplished the following: conducting an inventory of district enrollment by region; sharing achievements; identifying barriers in the field and finding solutions; redefining the roles and responsibilities of focal points from Siggil Jigéen and the district; and sharing the action plan for Year 4, implementation tools, and monitoring/evaluation methods for the approach. The workshop made the following recommendations:

- Provide orientation sessions for new head physicians on the PAQ approach
- Provide regular monitoring of tutors in partnership with regional program managers
- Expand support teams to other members of district medical teams
- Participate in coordination meetings for better institutionalization of the approach

6. Infection prevention and environmental protection in SDPs

This year the component emphasized infection prevention and environmental protection (PIPE), HAS production, and monitoring of multi-resistant bacteria (MRB).

PIPE training for providers: The component trained 529 providers (including 225 men)—reaching 172 SDPs, including 167 public and 5 private SDPs—in infection prevention and environmental protection in the regions of Louga, Diourbel, Kaolack, Tambacounda, Kédougou, Matam, Kolda, and Ziguinchor.

PIPE post-training follow-up for providers: In the Sédhiou region, the component organized three monitoring/post-training follow-up visits to ensure that trained staff are applying biomedical waste management and PIPE standards.

The main strengths from the monitoring are: HAS and cleaning supply availability in all SDPs; mastery of hand hygiene practices; availability of at least three trash cans for waste sorting in each SDP; and compliance with decontamination principles in some health posts.

By contrast, the weaknesses are: non-mastery of what to do in cases of accidental blood exposure; failure to comply with principles for cleaning premises or decontaminating supplies in some health posts; lack of sterilization in some health facilities due to lack of electricity; and unavailability of hand towels and water points in some health posts.

Recommendations were made to: (1) ensure the algorithm for cases of accidental blood exposure is available in SDPs; (2) have health committees order suitable containers for

decontaminating supplies; and (3) advocate among relevant officials to get electricity in some health posts.

Setting-up hydro-alcoholic solution production units: The component supported the National Nosocomial Infections Control Program to install four production units for hydro-alcoholic solution. They were set up in the Aristide Le Dantec Hospital, the Matlaboul Fawzeini Hospital in Touba, the Ulrich Lucke Hospital in Diourbel, and the regional hospital in Louga. The two existing units at the Principal Hospital and Fann Hospital received more inputs. Then 24 pharmacists and laboratory technicians (including 9 women) were trained in HAS production in Dakar, Louga, Touba, and Diourbel. These units will help prevent nosocomial infections in targeted health care facilities. The relevant nosocomial infections control committees will ensure that providers use HAS effectively to reduce morbidity and mortality rates related to nosocomial infections.

Multi-resistant bacteria surveillance: In partnership with the National Nosocomial Infections Control Program, the component supported surveillance of multi-resistant bacteria that cause nosocomial infections isolated in bacteriology laboratories in targeted health facilities.

The main goal of this support is to establish a baseline for MRB surveillance on a national level. Specifically, this involves:

- Introducing nation-wide mapping of health facilities that are potentially exposed to nosocomial risk
- Introducing mapping of facilities with a bacteriology laboratory potentially capable of detecting the various patterns of bacterial resistance
- Creating a list of hospital bacteriology laboratories that implement routine surveillance of MRB and/or highly resistant bacteria
- Conducting a comparative study of surveillance methods used by these laboratories and to investigate the found bacterial ecology

This will make it possible to map laboratories' capacities' to detect MRB and to make recommendations for better MRB management at the PHF level in Senegal.

7. Communication and promotion of health services

Key achievements are the production of job aids for providers, religious leaders' involvement in promoting the IPQS, and support for the MSAS' and partners' major events.

Production and dissemination of job aids for providers: The component made efforts to improve the availability of job aids in SDPs (see table below). These tools aimed to: (1) ensure that service delivery complied with FP legislation; (2) promote the knowledge and behaviors needed to limit health care-associated infections; (3) help limit health care-associated infections through hand washing; and (4) support compliance with new guidelines on managing malaria.

Table 6: Preparation of job aids

Product	Quantity	Status
Display on the range of contraceptive methods	1000	Currently being distributed
Job aid for infection prevention	1500	Currently being distributed
Poster on rubbing hands with HAS	2000	Currently being distributed
Poster on preventing malaria during pregnancy	2000	Currently being produced
"Treating Uncomplicated Malaria Effectively" posters	2000	Currently being produced
"Treating Uncomplicated Malaria during Pregnancy" poster	2000	Currently being produced

Involving religious leaders in IPQS promotion: The component will enlist religious leaders to promote the IPQS. Religious leaders are close to their community members and are forward thinking about important issues in daily life. These leaders play a key role in whether or not people adopt a behavior or use a service. This year the component developed a strategy to involve religious leaders by strengthening their capacities to deliver sermons on the IPQS. With support from a resource person, the component developed a draft of the sermon guide for the IPQS and a draft of the IPQS training manual for religious leaders. These various documents will be tested and validated in the Kaolack medical region.

The topics are:

- Maternal health (Birth spacing, protection during pregnancy and delivery, and post-natal consultations)
- Child health (Malaria control, disease management, vaccination, child nutrition, and exclusive breastfeeding)
- Newborn health (Protection of newborns)
- Adolescent reproductive health (Adolescence, management of puberty)
- Gender-based violence (Genital mutilation, male/female relationships, and violence prevention) and Hygiene and infection prevention (Hand washing)

Support for Ministry of Health and Social Action events: The National Malaria Control Program received support during World Malaria Day celebrations through the provision of 2000 adult-sized t-shirts and polo shirts and children's t-shirts. The shirts were used to convey the campaign's theme: "Invest in the Future. Defeat Malaria."

Next, the National Education and Health Information Service received support to broadcast the 2014 SISDAK on radio and television. Lastly, the National Midwives Association of Senegal received financial support during the International Day of the Midwife, used to print a scientific booklet, buy teaching materials, and cover conference costs for resource persons.

Sub-component 3: Improved human resources management in public sector health facilities

1. Strengthened capacities of ECRs and ECDs in human resources management

Development of a regional training plan: In Year 3, the component supported the MSAS Training Division to develop regional training plans for the Kolda, Ziguinchor, Sédhiou, and Tambacounda regions. Two workshops resulted in prepared drafts of training plans. These draft plans take into account critical training needs for each region based on the framework of the National Health Development Plan.

The MSAS strategy to develop training plans will rely on several technical and financial partners who will provide support based on their intervention area. Therefore, rather than the initially planned 14 regions, the HSI component will support the southern regions (Kolda, Ziguinchor, and Sédhiou), the eastern regions (Tambacounda and Kédougou), and Dakar region. At this stage of the development process for training plans, it is difficult to assess the impact of these tools, whose drafts were developed at the end of June. Going forward, the Department of Human Resources (DRH) will consolidate the various regional plans into one national training plan for the MSAS, to be validated by MSAS officials and disseminated to the various stakeholders.

Training for ECDs on improving performance: The component also supported the DRH Training Division under the MSAS to provide orientation on the performance improvement guide for 26 members (13 men and 13 women) of the ECRs, ECDs, and PHFs from Saint Louis region. Training modules dealt with the introduction of performance management, health governance, management, leadership, human resources management, financial resources management, service quality, and monitoring-evaluation.

After the modules were implemented, the orientation workshop continued critical analysis of how objectives have been structured and of the manual's content, target, and teaching strategy to strengthen health facility managers' skills in managing performance. Following the training, recommendations were made to correct insufficiencies in the guide and to incorporate practical tools identified by actors in the field before submitting it to an editorial review committee comprised of MSAS directors, MCRs, and MCDs. The Training Division worked on it and submitted the final version for validation. For Year 4, training sessions will be continued in the other regions.

2. Support granted to districts to implement a performance improvement system targeting SDPs and providers

Continued implementation of job descriptions in SDPs: Since this intervention is pegged to TutoratPlus, a booklet on organizing services, including human resources management,

was introduced in the training tools. Hence, trained tutors could use this session to help SDP managers implement job descriptions.

During the third quarter, tutors for the “Services Management and Organization” package supported the implementation of job descriptions for the various positions at 116 SDPs (112 public and 4 private) in eight regions. This year, job descriptions have been implemented in 743 SDPs. In the last quarter, 174 additional SDPs were able to establish job descriptions for the various positions due to the work of tutors from the services management and organization package. This brings the number of SDPs with job descriptions to 743 and annual performance to 124%.

Establishment of performance evaluation and recognition systems: The component supported six health districts (Diamniadio, Rufisque, Popenguine, Goudomp, Ziguinchor, and Diourbel) to implement a performance evaluation and reward system. These HDs could then evaluate the performance of their various SDPs by using a performance evaluation rubric to resolve gaps identified when TutoratPlus was launched. This rubric was used during the rapid situational analysis and assessed progress in filling gaps and the availability of services that did not exist before. They also use on-site supervision reports to assess skills acquisition for providing new services or improving their quality.

After the data from the rapid situational analysis were synthesized and analyzed, the six health districts identified the highest performing SDPs in their intervention areas.

These SDPs were recognized during public ceremonies that brought together all SDP managers, providers, administrative and local officials, and health committee members. For example, the Diorga and Tivaouane Peulh health posts in Rufisque health district received awards, while in Diamniadio health district, the Yenne health post and the health center were rewarded. These various SDPs, with support from their health committee and local government, overcame the most gaps and were able to provide some MNCH/FP services that were not available before.



Photo 1: Recognizing high performance in Rufisque health district

3. Support for increasing the number of staff in SDPs

Advocacy for health care staff availability: With component support, the DRH of the MSAS and Kaolack medical region conducted advocacy activities to support increased allocation of health care staff in the region’s SDPs based on iHRIS data. The advocacy workshop brought all stakeholders (administrative and local officials, health care professionals, and development partners) to the table to discuss the issue of insufficient human resources in health in the Kaolack region. Therefore, availability of and gaps in health care staff were highlighted,

presented by health district and by socio-professional category (physicians, state registered nurses, SFEs, etc.).

Local governments became aware of health care staff availability and shortfalls and are committed to curtailing gaps, while administrative officials have pledged to officially submit a regional advocacy document to the Ministry of Health. Going forward, the DRH will continue to organize regional workshops to advocate for increased SDP staffing in other regions where iHRIS software has been introduced. The challenge will be ensuring that the advocacy document has buy-in from the highest officials in the MSAS to solve staffing issues and provide quality human resources.

Mapping of health care staff: The component continued to support the DRH of the MSAS to extend the introduction of iHRIS software in the regions of Fatick, Kaffrine, Sédhiou, Tambacounda, Ziguinchor and Kédougou. Thus, iHRIS software has been introduced in eight regions, including the two pilot regions (Kaolack and Kolda). The extension approach held the ECRs and ECDs accountable for data collection and entry, under DRH coordination and supervision.

However, the DRH could not supervise the two pilot regions (Kaolack and Kolda) on iHRIS software use because extending the software to the other regions required a lot of time and human resources.

Advocacy for an increased number of staff in SDPs

The deputy governor of Kaolack: "This regional advocacy workshop helped us and all stakeholders grasp the situation for availability and gaps in human resources and to collectively seek solutions to the resource-gap issue with local governments, the DRH of the MSAS, and health committees."

Table 7: iHRIS registration by region

Region	Number of persons registered
Kolda	251
Kaolack	495
Fatick	276
Ziguinchor	431
Sédhiou	98
Kaffrine	186
Tambacounda	335
Kédougou	136
Total	1737

Support for trained staff: The component provided technical and financial support to the MSAS to recruit 20 health care providers. This recruitment aims to fill high-priority gaps in human resources in health posts that were closed due to lack of personnel or those with high-volume reproductive health or child survival activities.

The 20 hired health care providers have strengthened quality health services delivery

in their health care facilities, especially for reproductive health and child survival. Therefore, five health posts are now operational due to hired staff (the Diagon and Dianky health posts (HPs) in the Ziguinchor region and the Saré Kémo, Kabendou, and Nianing HPs in the Kolda region).

Health facility beneficiaries and managers all appreciate the midwives' contributions. For example, when interviewed, one beneficiary (by the initials A.B.) residing in Abéné (Diouloulou HD), stated that the Abéné HP now had increasingly more users of ANC and delivery services due to the presence of a midwife. Meanwhile, the MCD of the Diouloulou HD greatly appreciated the assignment of SFEs, particularly at the Kabiline HP where he recently conducted supervision; according to him, the assigned midwife currently oversees the decentralization of PMTCT.

Going forward, the DRH will conduct joint supervision missions in health facilities and communities to assess contributions made by these health providers. In addition, the component will support the DRH to document the hiring process so other partners who want to support the MSAS in health worker staffing may use it.

4. Use of technology to monitor training and performance

This year, the component achieved significant results in the use of Information Technology for Health. Several interventions using information technology for communications (ITC) were rolled out with the goal of improving the availability and use of health information for decision-making purposes at all levels and to eliminate stockouts of essential medicines and contraceptives.

Automated Data Exchange System During this period, the component worked with the Division of the Health and Social Information System (DSISS), the DSR/SE, and the Foundiougne health district on the key steps of the SEDA introduction process. This work made it possible to test and improve SEDA tools and especially to assess the relevance and feasibility of scale-up.

The component supported the MSAS to hold a meeting to share results from the SEDA pilot phase, attended by strategic partners from the central level, technical and financial partners from the MSAS, and participants in the pilot phase (ECDs and providers from the Foundiougne district). Discussions mainly covered identifying mechanisms to capitalize on providers' experiences in Foundiougne, developing a bridge between the SEDA and the District Health Information System-2 (DHIS2), defining a plan to transfer technological skills to the MSAS, and strengthening the partnership with mobile service providers. Positive results at the end of the pilot phase have generated renewed interest from MSAS partners and especially the DSR/SE, which has held three meetings on the SEDA. These meetings made it possible to finalize the revised

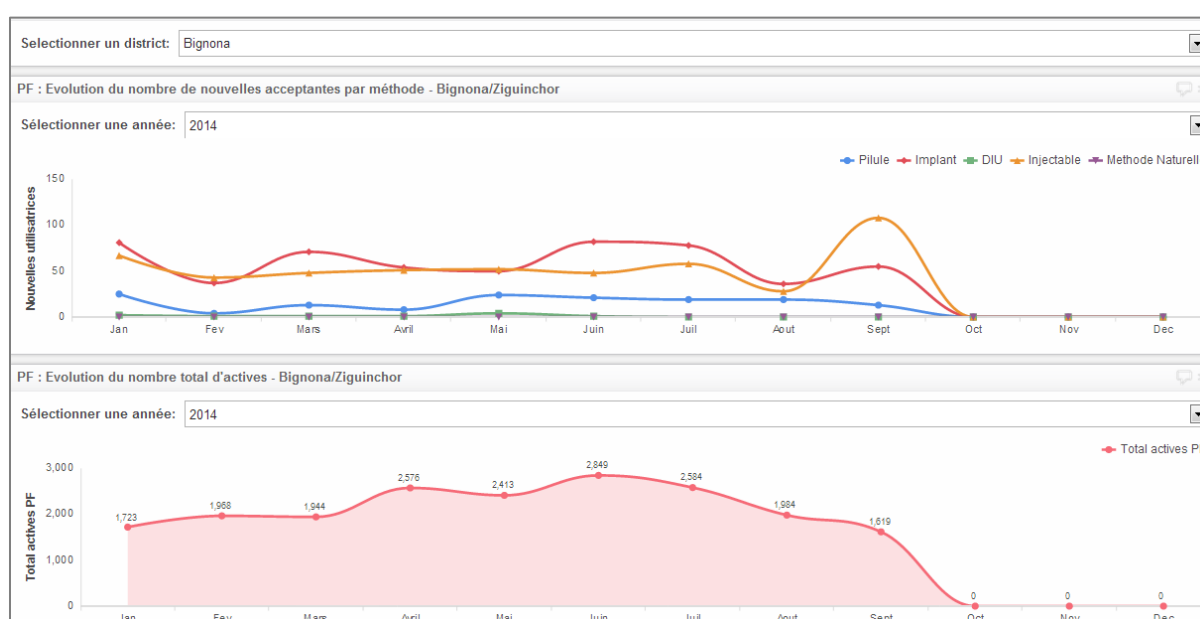


Photo 2: Training providers on the SEDA

indicators, prepare the extension phase, and establish the partnership through the preparation of a memorandum of understanding.

This year, the SEDA could be introduced in 21 districts in three regions (Thiès, Fatick, and Ziguinchor) covering 382 SDPs, or 29% of the country's SDPs. Providers and ECDs received orientation focused on using the SEDA dashboard to measure and monitor performance in their district or health facilities. The component found that by using the dashboards, providers and the ECDs can devote greater time to analyzing data and evaluating their performance. Among the supervision respondents who were informed about SEDA, 100% greatly appreciated it.

Figure 4: Example of a SEDA dashboard



Implementing an early warning system for stockouts: The component also succeeded in including a module for the early warning system for stockouts into the SEDA. The module expands the number of available indicators in the SEDA, taking into account consumption data for commodities and essential medicines.

Figure 5: Early warning messages for stockouts at the Diogo health post (Tivaouane district)

The screenshot shows a mobile application interface. At the top, there's a header bar with 'Diogo', 'ISSS', a notification icon with '3', and the time 'Oct 17 17:23'. Below the header, a message from 'Thies » Tivaouane » Diogo Assane Diouf +221775003428' is displayed. A long alphanumeric string is shown in a box. Below this is a table with 10 columns: 'Année du rapport', 'Mois du rapport', 'Microgynon disponible', 'Microgynon distribué', 'Microlut disponible', 'Microlut distribué', 'TCU 380A disponible', 'TCU 380A distribué', 'Dépo-provera disponible', and 'Dépo-provera distribué'. The data row shows values for 2014, 9, 239, 128, 57, 9, 7, 0, 291, and 211. Below the table is a 'Messages' section with three entries, each showing a timestamp, a phone number, a message text, and a 'Sent' status.

Année du rapport	Mois du rapport	Microgynon disponible	Microgynon distribué	Microlut disponible	Microlut distribué	TCU 380A disponible	TCU 380A distribué	Dépo-provera disponible	Dépo-provera distribué
2014	9	239	128	57	9	7	0	291	211

Messages			
17, Oct 2014, 17:24:24 +0000	+221775003428	Diogo : Rupture probable Ocytocine. Veuillez commander svp	Sent
17, Oct 2014, 17:24:24 +0000	+221775003428	Diogo : Rupture probable ACT Adulte. Veuillez commander svp	Sent
17, Oct 2014, 17:24:24 +0000	+221775003428	Diogo : Rupture probable Amoxicilline. Veuillez commander svp	Sent

Using ITC for mapping: In addition, through a partnership forged with the Jokkolabs community and the University of Gaston Berger in Saint Louis, the component has organized activities (training and a workshop) on using the open-source mapping software Quantum GIS at the central level in the Saint Louis medical region. Some 30 participants received orientation, including ECR and ECD members from the Saint Louis region, MSAS partners, WHO, and implementing agencies of the USAID Health Program. The component produced several thematic maps for monitoring intervention implementation, reconstructed all 76 districts in Senegal using the database on borders for the country's rural communities, and developed a beta version of a geo health portal.

Using ITC for learning: Implementation of the IPQS learning platform was delayed due to the unavailability of the DRH/Division of Continuing Education, the institutional bearer of this intervention. Nevertheless, the component was able to establish a technical working group in charge to developing the content and the learning platform. The presence and support of the Minister of Health's eHealth Advisor helped to strengthen institutional sharing and to advocate among MSAS officials to ensure this intervention's success. The outcomes are:

- Validation of training modules for the pilot phase
- Development of tools for using the portal (assessment tools, course syllabus, learner registration form, etc.)
- Identification of target audience (learners), trainers, and focal points
- A proposed on-line system to verify learning
- Configuration of the on-line learning platform and hosting by the State Information Agency
- Development of the draft plan to promote the learning portal

Sub-component 4: Development of relationships with private sector health facilities

1. Including the private sector in the TutoratPlus approach

Enrollment of private SDPs continued this year with the situational analysis of 69 private SDPs. Among these private SDPs, 66 signed a memorandum of understanding with districts receiving District Grants, bringing the number of private SDPs having signed memoranda of understanding to 144 by the end of Year 3.

The component supported the Partnership Division of the MSAS to conduct visits to discuss and review the memoranda of understanding. Thus, it visited the districts of Saint Louis, Podor, Dagana, Fatick, Kaolack, Foundiougne, Diourbel, Popenguine, Thiadiaye, Joal, Mbour, Thiès, Ziguinchor, and Diouloulou. The discussion meetings allowed the districts to standardize and discuss the clauses in the memoranda of understanding between them and private SDPs located in their areas of jurisdiction. Following these meetings, the two parties agreed to comply with the clauses in the memoranda of understanding.

These discussion meetings created a more dynamic partnership between the private SDPs and the districts, resulting in positive impacts. This has been illustrated in the Thiès district where an initial coordination meeting was held between the district and private SDPs who have formed an association. The meeting enabled the district to plan capacity building activities for the private SDPs and to inform them of MSAS health priorities.

2. Strengthening the IPQS as part of the medical services provided by companies

An on-site advocacy visit with company heads to promote the Company Enrollment Program to disseminate the IPQS and to promote health was held with the Division of Private Health Establishments, with technical and financial support from the component. This visit served to promote IPQS availability in these companies.

This visit involved companies in the regions of Kédougou, Tambacounda, Kolda, and Ziguinchor and met with 72 people (70 men and 2 women). These included company directors, managers of company medical services, personnel directors, and company employees.

The component held a capacity building workshop on the IPQS for 31 providers from companies. Representatives from various programs participated in the training, focusing on these topics:

- New guidelines for the management of malaria
- Infection prevention and environmental protection
- Health at the workplace
- An update on family planning

The meeting resulted in a PNLN commitment to enroll companies that have been trained into a program to monitor malaria control activities.

3. Involving men employed in large companies through information about IPQS with emphasis on reproductive health/family planning

Advocacy visits to companies in the south were also an opportunity to advocate for setting up an information program for male employees. This program emphasizes behavior change communication and greater involvement of men in their families' health.

The component partnered with the Association for Company Paramedical Staff to train 31 private-sector providers (including 8 women) from 27 private companies in interpersonal communication techniques. The training used role plays and demonstration techniques to help the various providers gain the skills needed to convey key information on the IPQS and to improve client reception so they may resolve health issues.

Booklets on key messages to help men promote family health were prepared, and 250 booklets are being printed for distribution in companies. These booklets will support paramedical staff in companies during interpersonal communication sessions with users of their services.

4. Mobilizing private sector leaders to ensure increased IPQS availability

As part of strengthening the public-private partnership (PPP), the component supported the Partnership Division of the MSAS to begin implementation of the partnership project. Aware of the positive impact that public-private partnership projects can have on improving the quality of health services, the division partnered with the Division of Public Health Establishments to organize discussion days to boost implementation of PPP projects in hospitals.

Thus, the component supported holding a workshop on hospital governance through public-private partnership. This workshop mobilized hospital directors to seek PPP solutions for efficient hospital management and renewed efforts to rebuild technical platforms for these hospitals. Following the workshop, the directors mastered the implementation process for PPP projects and suggested ideas for PPP-type projects. The MSAS and the Ministry of Investment Promotion will be responsible for supporting the search for private partners for these projects. This workshop had 37 participants (28 men and 9 women), including the Director of Investments; the Director of Planning, Research, and Statistics of the MSAS; the MSAS deputy technical advisor; the head of the MSAS Partnership Division; and all directors of type-1, -2, and -3 PHFs.

5. Involving pharmacies in delivering quality services

The component supported training on the IPQS for 91 private-sector pharmacists. Training was held in the regions of Thiès, Diourbel, Mbour, and Kaolack, and dealt with malaria case management, the management of diarrhea with ORS/zinc, family planning, and the management of acute respiratory infection among children.

The component also supported IPQS training for 67 pharmacy counter-service staff (including 32 men and 35 women) in Dakar. This training dealt with the IPQS and the teaching modules

for malaria case management, case management of diarrhea with ORS/zinc, and FP counselling. Training for pharmacy counter-service staff currently does not cover treatment of acute respiratory infections.

The component met with the Health Communication and Promotion component (implemented by ADEMAs) to coordinate and align their activities in the strategy to involve pharmacies in delivering quality services.

Moreover, the component strengthened the family planning capacities of ADEMAs medical visitors and their technical staff (10 workers, including 1 woman). The training aimed to provide technical arguments that may improve advocacy for products through social marketing.

In further efforts to involve pharmacies in providing quality services, the component began discussions on providing FP in pharmacies. Thus, a meeting was held at the DSR/SE to advocate for expanding FP delivery in private pharmacies (pills and injectables). This discussion meeting brought together all stakeholders—29 participants from the Order of Pharmacists, the Pharmacists Union, the Pharmacy Division, and the DSR/SE along with technical and financial partners. During the meeting, representatives from the Pharmacy and Medicines Division, the Order of Pharmacists, and the Private Pharmacists Union revealed that FP delivery in pharmacies has been hindered by regulations that do not allow pharmacists to provide health services, such as an injection. This re-emphasized the need for the public health code revision that was begun four years ago and is still incomplete. Private pharmacists can play an undeniable role in service delivery; the key step is to sensitize officials. However, this should be preceded by developing a rationale for revising regulatory laws with the union, the Order of Physicians, the Order of Pharmacists, the MSAS legal advisor, the Midwives Association, the Nurses Association, etc.

6. Expanding IPQS in the private and semi-public sectors

The component made significant efforts to strengthen the capacities of private- and semi-public-sector providers with the goal of expanding the IPQS. Therefore, the component partnered with the Private Paramedical Association to support training for 16 private health workers (3 men and 13 women) working in contraceptive technology in the Dakar suburbs. Training emphasized long-term and permanent methods, management of the FP file, and infection prevention. The training was rolled out in three stages: (i) theoretical teaching; (ii) practicing on mannequins; and (iii) practicing in the field for two days (the field sites were the family planning centers of the Senegalese Association for Family Welfare, the Gaspard Camara Health Center, and the PMI Institute of Social Hygiene in Médina). Following the training, all the providers expressed their satisfaction, and 60% of them showed specific interest in long-term and permanent methods.

As part of the implementation of standards for private-sector providers, the component also supported training for pediatricians who are members of the pediatric board to use the “WHO Anthro” anthropometric software. The training targeted 23 board members (15 men

and 8 women). This training aimed to include this important module into screening for malnutrition in postgraduate education programs at Cheikh Anta Diop University in Dakar and the UFR Santé University in Thiès.

The component strengthened the capacities of 39 private-sector health workers in malaria case management. Training took place in the districts of Rufisque and Thiès and was conducted by district medical teams. Besides building capacities, training sessions helped build relationships between members of the district medical teams and private-sector staff in these districts.

Private-sector providers then organized into associations in Rufisque and Thiès, which enabled the Thiès district to hold coordination meetings with providers from private SDPs.

After the situational analysis of the private sector for malaria, the component held a meeting to share results with the various stakeholders (PNLP, the Directorate of Health Facilities, USAID, the private physicians union, the Physicians Order, the private paramedical workers association, the private Catholic dispensaries association, and a few private providers (in Touba, Thiès, and Kaolack) who received visits during the SA). Attended by 63 participants (38 men and 25 women), this workshop served to share results from the situational analysis and to make recommendations geared toward strengthening the partnership between the public and private sectors and overcoming training gaps.

One of the recommendations was to expand the evaluation of the private sector to other priority health sectors. Thus, the component suggested supporting the MSAS to conduct supervision in private health facilities in Senegal. The supervision should highlight gaps in the private sector for service delivery and generate possible solutions to overcome the noted gaps.

Thus, the component supported supervision of private health facilities combined with the collection of private sector data. The supervision involved 164 private health sectors in 11 regions: Dakar, Diourbel, Fatick, Kaolack, Saint Louis, Louga, Tambacounda, Thiès, Ziguinchor, Sédhiou, and Kaffrine.

The table below shows a monograph of the visited facilities in the regions of Dakar, Diourbel, Fatick, Kaolack, Saint Louis, Louga, Tambacounda, Thiès, and Kaffrine and involves 164 facilities instead of the previously mentioned 178 (these data are being processed).

Table 8: Monograph of Private SDPs by region

Region	Clinic	Semi-private practice	Private practice	Private Catholic health post	Private hospital	Company health services	Private health center	Total
Dakar	8	15	2	0	3	3	1	32
Diourbel	2	11	9	2	0	5	2	31
Fatick	1	5	0	6	0	0	1	13
Kaolack	9	6	1	2	0	0	1	19
Saint	1	3	3	3	1	3	0	14

Louis								
Louga	4	5	2	0	1	0	1	13
Tamba-counda	2	0	1	0	1	2	2	8
Thiès	7	11	3	2	2	2	0	27
Kaffrine	0	0	2	2	0	3	0	7
Total	34	56	23	17	8	18	8	164

The supervision made it possible to analyze IPQS health services delivery in private SDPs and to seek corrective measures for gaps noted in health services delivery. In the area of maternal health, initial analyses found that: 58 facilities, or 35.37%, deliver maternity services. Of this number, 61.52% provide PNC-1, 61.52% provide PNC-2, and 55.17% PNC-3.

During the next fiscal year, the component will prepare a supervision report and ensure that DHS data is included to shed light on the situation in the private sector. Lastly, the component supported the NGO HASDET to extend their package of services in the Diourbel region. The partnership with HASDET began with the signing of a memorandum of understanding between the NGO and the Touba health district. This support allowed the NGO to expand their package of services through FP services delivery in advanced strategies during sessions to monitor/promote children's growth in the NGO's nutrition sites.

Supervision and monitoring & evaluation

1. Strengthening supervision systems at the district, SDP, and community level

Supervision is a key activity in improving performance in health posts; however, it faces numerous challenges. Through direct financing and the component's efforts, supervision has resumed, although minimally. Hence, during this past year, 125 SDPs (including 10 health centers and 115 health posts) were supervised by the districts.

For example, supervision in the Khombole district sought to assess the implementation capacity of the integrated services package in the health district's facilities. Supervision should check the availability of IPQS services in facilities, identify gaps and problems related to facility management, and suggest solutions. Of the 17 facilities in the supervised district, 15 are in the green (100% availability of IPQS services), while 2 are in the red (services available but quality must improve). After the supervision, 17 plans to solve problems were prepared for each health post. One of the strengths noted during the supervision is the availability and proper filling-out of newly revised management tools that attests to the positive effects of the component's support in improving health data availability.

In addition, integrated supervision of community facilities implemented by health post staff has performed well through direct funding for this intervention. In effect, 1491 supervisions of operating health huts conducted by providers from health posts were reported during the advanced strategies in 839 health huts. Health hut supervisions are conducted during advanced strategies and serve a formative function. The rubric for health hut supervision deals with community case management of acute respiratory infections, diarrhea, uncomplicated malaria, essential newborn care; the availability of essential medicines and

commodities (ACT, RDTs, ORS/zinc, Co-trimoxazole, contraceptive pills, and insecticide-treated mosquito nets); data collection; and hut management.

Main strengths reported during these supervisions were:

- For the management of diseases overall, the management of uncomplicated malaria and diarrhea was satisfactory in all supervised huts.
- For the management of tracer drugs and commodities, good availability performance was reported for RDTs, ACT, and Co-trimoxazole in more than 90% of supervised health huts. Also, drug management tools were properly maintained.
- Deliveries assisted by a matron in health huts and home births were reported; essential newborn care, especially early breastfeeding and umbilical cord care, was provided.

Key areas for improvement are summarized as follows:

- For the management of diseases, most health huts reported unsatisfactory management of acute respiratory infections.
- For drug management, an overall unavailability of long-lasting insecticide-treated bednets was noted in health huts throughout the year. There were frequent ORS/zinc stockouts. However, management tools were properly maintained.
- Regarding health hut management, three major problems were noted: the health hut committees no longer hold meetings, the health huts have low attendance, and the health hut staff do not feel sufficiently motivated with incentives.
- One of the main problems with health hut supervision is the time that head nurses devote to this activity. During the advanced strategies, the nurses place priority on providing services and devote very little time to supervision.

Primary recommendations from these supervisions are:

- For community-based actors: renew the health committees with support from the administrative authority and begin discussions to implement an incentive system for health hut staff.
- For head nurses: conduct supportive supervision more regularly in health huts and devote greater time to supportive supervision during the advanced strategies.

2. Increased availability and use of health data for decision-making purposes

Strengthened capacities in the Information System for Management (ISM): As part of improving health data availability and use for decision making, the component has supported the MSAS since Year 1 through the revision and printing of management tools and training for service providers on using these tools. This year, the component supported training for 745 providers (57% women) from 486 service delivery points, including 40 private and 446 public SDPs.

Also as part of improving the national information system, the component provided technical and financial support to revise management tools for sanitation and hospital services. These revised tools are currently being disseminated.

In addition, the component supported the organization of a national workshop to develop the 2010–2013 Statistical Yearbook, for which the report is still not available.

As a reminder, last year the component worked in synergy with the HSS and HIV/TB components to support retrospective data collection from July 2010 to March 2013 in the regions of Ziguinchor, Sédhiou, Kolda, Kaffrine, and Fatick. This data collection is part of implementing the MSAS roadmap for rebuilding the data system following the lifting of the union's withholding of data.

These various interventions helped improve the availability of newly revised tools in the SDPs and to improve the skills needed to use the new ISM tools, as shown by the supervision results.

Strengthening workers' capacities in monitoring-evaluation: Through a course organized by the African Center for Higher Education in Management (CESAG), 15 participants (ECD, ECR, and central level staff) deepened their understanding of the concepts, principles, and monitoring-evaluation methods for health programs and familiarized themselves with the tools used to collect, analyze, and interpret qualitative and quantitative data. Thus, training these staff members will facilitate the use of information to improve health program performance.

Support for DHIS-2 introduction: Following the revision of ISM tools and provider training, having a database to compile, process, and disseminate data collected in real time remains a key challenge. Specifically, the system's current software—the SYSNIS (Computerized System of the National Health Information Service)—is hardly used, particularly due to functionality issues (bugs, lack of updating, and inadequate staff training). These operational issues led the DSISS to use the DHIS2 software to collect, transmit, and process health data. Positive feedback from the ECDs, ECRs, and the central level along with good results from post-training follow-up enabled the DSISS to plan to mainstream the platform in other districts and regions. Moreover, the DSISS could rely on SEDA extension (which maintains a bridge with the DHIS2) for quick uploading of some control data for priority programs in real time.

Support to restart monitoring: In response to the MSAS circular note on resuming monitoring, the component supported the plan to restart monitoring that was developed by the Directorate General of Health Services (DGS). Monitoring is a participatory exercise for self-evaluation and review of facility performance as well as for developing plans to resolve issues. It is supposed to provide SDP staff a framework to monitor the outcomes of TutoratPlus implementation, particularly on-site supervision, the improvement of services quality, and community use of SDPs. Thus, monitoring allows for promoting effective local use of data by SDP staff for decision-making purposes to improve health services accessibility and coverage.

Thus, the component supported monitoring in the two regions of Saint Louis and Dakar in eight districts: Dakar-Centre, Rufisque, Mbaob, Saint Louis, Dagana, Podor, Richard Toll, and Pété. Monitoring was done in 77 SDPs. The component also supported supervision of monitoring by the central level of the MSAS in the 10 regions.

The supervision goals were to take stock of the implementation of monitoring in the first six months of the year in the regions, to recover the data reported on the validated template, and to work with the region to plan monitoring activities for the second half of the year. At the time of supervisor visits, nine regions were in the process of monitoring the different steps while five regions had not begun, due to lack of funding.

After the supervision, all the regions had plans for the second round of monitoring for January 2015. The staff training step was a noted strength of the monitoring. Provider training helped familiarize staff with the new monitoring guide. The supervision teams highlighted the good quality of collected data. Monitoring also improved the collection of services data. Lastly, health committee participation helped them to better understand the process and resulted in their greater involvement in identifying problems and making decisions.

However, problems in some districts or regions hampered the monitoring process:

- Providers in some districts have not mastered the monitoring process, or training has been insufficient due to lack of financial support. This has affected the quality of collected data.
- Regarding the actual guide, problems were noted in maintaining a standardized understanding of some indicators. Also, sufficient quantities of the guide were not available in the districts.

The main recommendations drawn from these supervisions are:

- Resend the memos from the Minister on relaunching monitoring to generate greater enthusiasm
- Revise the monitoring guides and make them available in the medical regions before starting the next round of monitoring
- Advocate among IntraHealth and other partners, if possible, to continue support to implement monitoring
- Request that the mayor and health committees (of health centers and health posts) finalize the budget
- Request support from the regional and central level to implement monitoring (training and implementation)

Documenting and sharing high-impact approaches: The process to document high-impact approaches began this year with two approaches, specifically the integration of FP in vaccination services and the acceptability of the post-partum IUD. For the first approach, data were collected and a team of consultants is working on the report. Meanwhile, the protocol

for the acceptability of the post-partum IUD was submitted to the ethics committee, and the team is waiting for approval to start the approach.

3. Strengthening coordination of interventions to improve service delivery

Frontline staff at the DSR/SE facilitated coordination at the DSR/SE and within the DGS by participating in key meetings to plan and discuss the IPQS and services delivery. Then the coordinator of the National Program for Quality was appointed as the HSI component focal point at the DGS. In addition, a meeting was held with all MSAS services.

Coordination of the component's implementation

In addition to internal meetings, the component participated in inter-agency meetings mainly on FP and direct financing. At the same time, it made efforts to work in synergy with the other components, such as:

- Community Health Component: to monitor the implementation of identified advanced strategies and RED approaches and to improve IPT2
- Health Communication and Promotion Component: to train pharmacists on the IPQS
- HIV/AIDS Component: to support the MSAS Gender Unit and Office of Violence and Trauma Prevention

Gender

In Year 3, the component prioritized gender mainstreaming in interventions and activities through the following:

- During the situational analysis of TutoratPlus in 21 districts, a questionnaire was given to SDP service beneficiaries to assess their perspectives on treatment equity, freedom of choice, respect, and affordability of services. These questionnaires will be used to show the districts what gaps arise when taking into account users' perspectives for equal access to care and to increase the use of services.
- As part of PAQ implementation, 29 PAQ teams were set up in 29 SDPs, bringing the total number of PAQ committees to 644. Each PAQ team set up an internal committee that observes male/female parity. The PAQ committees' mission is to monitor the implementation of the drafted PAQ plans. The presence of women on these committees ensures that women's perspectives on delivering quality services are taken into account and also facilitates equal participation of men and women in health issues.
- Given women's preference to receive some types of care from female staff, the component preferred hiring midwives when supporting the hiring of skilled staff in the regions of Kolda and Ziguinchor. In all, 14 of the 20 positions were assigned to midwives through a rigorous selection process. This decision, seen as an equity measure, will result in more women heading health posts. It will also support greater use of services by women, who will be dealing with a female staff.

- The component supported the Office of Violence and Trauma Prevention of the Directorate General of Health Services to develop a protocol for managing victims of gender-based violence and a flowchart on providing care for victims of violence.
- The component supported the Gender Unit in collaboration with the HIV/AIDS and Tuberculosis component to develop a gender mainstreaming strategy for health policies and programs. This workshop served to define strategic objectives for mainstreaming gender into health policies and programs, develop steps for gender mainstreaming, develop tools for the gender audit, and validate gender indicators in the health sector.
- The component conducted its gender audit through an on-line survey that identifies staff knowledge about gender and gets their views on how to improve gender mainstreaming in the component's policies, strategies, and interventions. This audit was extended to other projects implemented by IntraHealth.

Compliance with family planning regulations

During Year 3, the component took into account compliance with family planning regulations, particularly through training. As part of TutoratPlus implementation, 165 providers (81% women) received on-site training in FP counseling. The on-site supervision allowed for coaching providers in how to ensure clients have clear information and free choice about choosing a method for birth spacing, in compliance with USAID requirements for FP. The component provided orientation for 152 newly trained tutors (47% women) on complying with FP legislation and regulations. Lastly, the component developed tools to monitor compliance with regulations at the health district and SDP level. These tools were included in the component's supervision rubric and administered in 100 public and private SDPs.

The supervision visit (of 95 sites) also evaluated compliance with US government regulations for FP in SDPs. Supervision team members checked various aspects (posters and other tools). For all other indicators, SDP providers responded to questions presented in the table below.

Table 9: SDP compliance with United States government requirements for FP (N=87)

Items to be checked	% Yes
Is there a "Tiaht poster" or an equivalent poster providing full information on FP methods posted on an SDP wall, or are equivalent informational materials available in the SDP that describe the adverse side effects and health risks of the various FP methods?	45
Do providers use the "Tiaht poster" or equivalent informational materials (flip charts or displays) to provide clients with clear and complete information on the chosen FP method (the benefits, adverse side effects, and health risks, including the conditions that would make using the method inadvisable for the client)?	66
Are the clinical staff trained on the Tiaht and other US government legislative regulations and policies regarding FP?	36

Items to be checked	% Yes
Do providers provide clear and complete information to clients on the various FP methods without encouraging them to accept a particular method of FP during counseling?	78
Do providers provide information to clients on the benefits, health risks (including the conditions that would make using the method inadvisable), and known adverse side effects of the FP method during specific counseling?	77
Is there a range of FP methods to ensure clients make a free choice from among approved methods?	86
Do staff receive a bonus payment for achieving FP targets?	0
Is there a set target or quota for staff for needs other than program planning?	0
Has the SDP received equipment purchased by the project for abortion services?	0
Are voluntary sterilization services provided?	2
If YES, is a consent form routinely filled out, signed, and archived for each client? (n=2)	100

Compliance is generally high for counseling, but there is a lack of job aids (posters, visual aids) to help providers deliver counseling based on the standards. Although the percentage of providers who have been trained on the United States legal requirements and policies is low, it is possible that providers have received training on the necessary content but have not connected it to the US requirements.

Compliance with regulations for environmental protection

As specified in the environmental protection plan, the component ensures compliance with environmental regulations through capacity building for providers in biomedical waste management and infection prevention. The main achievements reported for Year 3 are:

- Training of two staff members from the central level (2 women) by USAID in complying with environmental regulations
- Training of 103 providers (53 women and 50 men) on infection prevention, including biomedical waste management and environmental protection
- Supervision of 95 SDPs in infection prevention and PIPE

Compliance with US government regulations for environmental protection was evaluated by asking providers from supervised SDPs the following questions during a recent supervision visit. When possible, the team members physically checked compliance (for example, the sterilization equipment). Table 10 below summarizes the monitoring results.

Table 10: Monitoring of compliance with environmental protection in SDPs (n = 95)

Items	% Yes
Staff (trained staff, community health workers, matrons, and cleaning staff) are trained in PIPE	67
Providers use disposable syringes and gloves	98
SDP has plastic receptacles and products for equipment decontamination	76
SDP has equipment to sterilize instruments (autoclave, poupinel, etc.)	72
The SDP has a sealed trash can with a lid or a pedal trash can in each specified	57

Items	% Yes
location (consultation/care room, delivery room, waiting room, hallways, courtyard, etc.)	
Trash cans are emptied regularly before they are too full	90
Providers sort household waste and biomedical waste	48
A suitable type of container is used to store sharps separately (for example, a safety box)	87
The SDP has a secured interim storage area (accessible only to authorized staff)	61
Staff responsible for transporting, storing, and discarding biomedical waste are equipped with protective equipment (glasses, gloves, boots, and mask)	16
There is a specific location for waste disposal (for example, an incinerator, a landfill pit, etc.)	71
If yes, the disposal site has no traces of infectious waste, syringes, or other sharps waste (n=67)	40

Only two-thirds of SDPs reported having trained staff, and compliance ranged considerably depending on the criterion. Nearly all SDPs have disposable gloves and needles. Sharps management was generally good, and most SDPs emptied trash cans frequently. However, many service delivery points lack essential equipment, including for instrument sterilization and medical waste disposal.

III. Main challenges

Despite satisfactory implementation, the component faces some challenges:

- **Inadequate coordination from the central level with the decentralized level:** Actors in the field often mention lack of coordination to explain the postponement of some activities that are rescheduled due the activities at the central level.
- **Ownership by the ECDs with support from the medical regions to monitor on-site supervision activities for tutors during their time at the SDPs:** Irregular planning by the MCDs of tutor visits for on-site supervisions and by SDPs, ECRs, and ECDs of activities is a challenge in some districts. We are trying to improve this by getting the ECDs to increase the rate of tutor visits in the SDPs. This will improve coverage and ensure data from the on-site supervisions are collected and analyzed by the ECDs with a view to improve on-site supervision coverage in private SDPs.
- **Coordination with other MSAS technical and financial partners:** The MSAS receives support from other partners such as UNICEF, UNFPA, and the Micronutrients Initiative to cover interventions such as supervision, the use of ITC, and IPQS capacity building. The lack of formal coordination within the MSAS leads to the cancelation of some component activities to avoid duplications. For example, the component planned to support all regions in developing regional training plans, but ultimately only six regions received component support. The Belgian Technical Cooperation

supported the central regions (Diourbel, Kaolack, Kaffrine, Thiès, and Fatick) and the Luxembourg Cooperation supported the regions of Saint Louis, Louga, and Matam.

- **The new health context** due to the Ebola epidemic in the sub-region: This new health context also affected the implementation of routine activities that were delayed, especially in the bordering regions of Kolda and Kédougou.
- **The delay in implementing PPP** projects related to health: This delay is mainly due to the lack of MSAS capacities to develop a PPP project and to monitor the process established by the Ministry of Investment Promotion. Also, there are delays in procedures for launching PPP projects at the National Council for Public-Private Partnerships.
- **The diversity and insufficient coordination of ITC interventions**
Unfortunately, there are several initiatives in the area of ITC that do not maintain effective coordination. Defining a strategic plan for health-related ITC by the Ministry of Health and Social Action should help improve coordination.

IV. The way forward and priorities for Year 4

For Year 4 of implementation, the component will focus on:

- Intensified scaling-up of high-impact interventions for maternal, newborn, and child health
- Greater ECR and ECD accountability in of activity implementation
- Greater expansion of the component's interventions, particularly in Kédougou region where the IPQS should be implemented
- Monitoring, documentation, and sharing of the component's key interventions
- Strengthening of continuous planning, coordination, and technical exchange with all MSAS entities for the gradual institutionalization and perpetuation of component interventions
- Improved synergy with other Health Program components
- Greater involvement of private-sector partners through the development and promotion of projects that are suitable for the PPP
- Collaboration with other MSAS partners (such as UNICEF, UNFPA, and LuxDev) to improve services delivery for effective use of resources for family planning, maternal health, equipment for SDPs, and securing essential commodities and medicines.
- Maintaining a high ethical standard to ensure compliance with USAID and MSAS requirements and expectations in cross-cutting areas such as gender and compliance with environmental regulations and FP requirements.
- Support for the MSAS for the implementation of the Ebola response plan

V. Financial report

Name	% Allocation by Technical Area	Total Amount Earmarked/Obligated To Date	Prior Periods' Expenditures	Year 3 Total Expenditures	Total Expenditures To Date	% Expended
Malaria	23%	\$ 5,088,613	\$ 2,125,123	\$ 1,474,894	\$ 3,600,017	71%
Tuberculosis	0%	\$ 50,000	\$ 45,444	\$ -	\$ 45,444	91%
Nutrition	8%	\$ 1,710,000	\$ 674,167	\$ 712,436	\$ 1,386,603	81%
Maternal & Child Health	34%	\$ 7,472,387	\$ 4,105,730	\$ 3,295,430	\$ 7,401,160	99%
Family Planning & Reproductive Health	34%	\$ 7,624,000	\$ 4,064,387	\$ 3,848,024	\$ 7,912,411	104%
HIV-AIDS	1%	\$ 194,000	\$ 53,271	\$ 63,016	\$ 116,287	60%
TOTAL	100%	\$ 22,139,000	\$ 11,068,122	\$ 9,393,799	\$ 20,461,921	92%

- **Nutrition (81%):** For nutrition, we noted a rise in achievement rates for the earmarked amount, from 40% in Year 1 to 51% in Year 2 and 81% in Year 3. Efforts will be made during Year 4 to achieve 100%.
- **Malaria (71%):** For malaria, the end of Year 1 showed a 55% increase. At the end of Year 2, this rate was 73% compared to 71% at the end of Year 3. The component will focus on reducing this gap this year.
- **HIV/AIDS (60%):** Analysis of the growth rate for using these funds shows a 28% rate at the end of Year 1, 36% at the end of Year 2, and 60% at the end of Year 3. This year, we expect to reach 100% for this line item.

VI. Annexes

Annex 1: Performance Monitoring Plan

The Health Services Improvement (HSI) component of the USAID health program is a five-year project that is implemented by IntraHealth International in partnership with Helen Keller International (HKI), Réseau Siggil Jigéen (RSJ), and Medic Mobile through cooperative agreement AID-685-A-11-00003.

The goal of the project is to overcome major challenges in the delivery of quality health care services (accessibility, operations, health care staff, and the private sector) to support the Senegalese government's efforts to achieve the Millennium Development Goals.

The component's primary objective is to strengthen the delivery of quality health services at health facilities through the following four sub-components:

- 1) Increased access to an Integrated Package of Quality Services (IPQS)
- 2) Improved quality of health services in health posts, health centers, and regional hospitals
- 3) Improved human resources management in public sector health facilities
- 4) Development of relationships with private sector health facilities

Services data availability was a tremendous challenge for the component over the last two years of implementation. For this third year, the component has implemented strategies to access reliable data from SDPs to overcome this challenge. Therefore, when reviewing the Performance Monitoring Plan, the component will do the following, in addition to the conventional use of project activity reports:

- **Data presented in the SEDA:** The SEDA is a platform for sending and analyzing health data through the mobile phone network. The component introduced the SEDA in partnership with the DSR/SE and the DSIS in 382 public and private SDPs in 20 districts in the regions of Thiès, Fatick, Ziguinchor, and Kaolack. Data from October 2013 to August 2014 were used, while data from September have not been validated yet by the medical teams. The completion rate for disease management reports indicate that malaria is 66%, childhood disease is 64%, and maternal health is 68%. These data are certainly not representative of the entire country, but they identify reported trends for indicators in the districts covered by SEDA.
- **Data from the supervision of SDPs:** Given the lack of routine data validated by the National Health Information Service, the component partnered with the ECDs at the end of the fiscal year to conduct supervision of a sample of 100 SDPs in 40 randomly drawn health districts from all 14 regions.

- **Distribution data for the PRAs and districts:** The couple-years of protection were estimated based on PRA and district distribution data. However, the component continues to collaborate with the Informed Push Model project to collect consumption data from SDPs.

Performance Monitoring Plan: October 1, 2013 – September 30, 2014

#	Description of indicators	Disaggregated by	FY14						Comments
			FY14 Target	Achieved Q1	Achieved Q2	Achieved Q3	Achieved Y3	Achievement rate for Y3	
Sub-component 1: Increased access to an Integrated Package of Quality Services									
1	Percentage of service delivery points offering an IPQS in a program supported by the United States government	Altogether	100%	74%	74%	74%	108%	108%	This indicator is measured using data from the situational analysis of TutoratPlus. During this year, 405 SDPs, including 69 private SDPs, were enrolled for IPQS delivery. This brings the number of SDPs that deliver the IPQS to 1303, or 108% of the target of 1211 SDPs.
2	Number of service delivery points with family planning counseling supported by the US government	Altogether	1211	855	855	855	1303	108%	For this indicator, we reported on all SDPs that deliver the IPQS, where FP counseling is included, totaling 1303 SDPs.
3	Couple-years of protection by method	Altogether	157,633	ND	146,091	ND	794,591	93%	Despite concerted efforts to relaunch the information system, complete consumption data are not available yet for the SDPs. We resorted to using amounts distributed by PRAs for the period October 2013 to September 2014 to assess the indicator. IntraHealth will continue to provide its technical assistance to the Ministry of Health to support effective resumption of uploading routine data.
		Pills	-	-	16,608	-	94,810		
		Implants	-	-	57,646	-	311,022		
		IUD	-	-	23,860	-	123,280		
		Injectable	-	-	40,487	-	229,731		
		Condoms	-	-	7124	-	14,942		
		Emergency contraception	-	-	150	-	2055		
		CycleBeads	-	-	216	-	18,752		
4	Quantity of	Altogether	NA	NA	NA	NA	NA		

#	Description of indicators	Disaggregated by	FY14						Comments
			FY14 Target	Achieved Q1	Achieved Q2	Achieved Q3	Achieved Y3	Achievement rate for Y3	
	contraceptives delivered, by method	Pills	-	-	249,122	-	1,422,150		
		Implants	-	-	15,170	-	81,848		
		IUD	-	-	5187	-	26,800		
		Injectable	-	-	161,948	-	918,922		
		Condoms	-	-	854,897	-	1,793,033		
		Emergency contraception	-	-	2993	-	41,100		
		CycleBeads	-	-	144	-	12,501		
5	Percentage of pregnant women who received intermittent preventive therapy during their ANC during their last pregnancy (IPT2)	Altogether	61.80%	-	-	-	66%	107%	These data are from the SEDA platform for the period from October 2013 to August 2014 for 382 SDPs in 20 districts. The completion rate for reports submitted in the period ranges from 64% to 68%, according to the indicators. This is the ratio of the number of women who received IPT2 compared to the number of first contacts during the same period. Overall 44,899 women, including 23,163 in rural and 21,736 in urban settings, received IPT2, totaling 67,725 first contacts.
		Urban	-	-	-	-	64%		
		Rural	-	-	-	-	69%		
6	Percentage of women receiving active management of the third stage of labor through a program	Altogether	90%	ND	ND	-	96%	106%	This is the ratio of the number of women who received AMTSL compared to the number of assisted deliveries during the same period. Overall, 41,144 women received AMTSL (including 18,976 in rural settings) for 43,031 deliveries assisted by trained staff
		Urban				-	64%		
		Rural				-	69%		

#	Description of indicators	Disaggregated by	FY14						Comments
			FY14 Target	Achieved Q1	Achieved Q2	Achieved Q3	Achieved Y3	Achievement rate for Y3	
	supported by the US government								(including 19,433 in rural settings).
7	Number of women who received uterotonic drugs in the third stage of labor through a program supported by the US government		327,434	ND	ND	ND	41,144	13%	Data collected through the SEDA for 20 districts show that 41,144 women received uterotonic drugs. The low performance rate is because the target concerns all regions while the SEDA data are only from 382 SDPs in 20 districts. In terms of coverage in these districts, 96% of women received a uterotonic drug during deliveries.
8	Number of service delivery points (type-1 and type-2 health centers; and type-1 and type-2 public health facilities) funded by the US government providing life-saving maternal care		85	ND	ND	86	86	101%	Based on data from the SA conducted this quarter, 10 SDPs deliver life-saving maternity care; this number is in addition to the baseline number of 76 SDPs. Also, the component is working with ECDs and tutors for the MNCH and FP packages to continue to document the indicator in all enrolled SDPs.
9	Percentage of providers who comply with standards and protocols related to the management of labor and delivery in		50%	ND	ND	47%	53%	106%	During supervision, this indicator was calculated for 95 SDPs where 101 providers were evaluated on using the partograph. The five last partograph forms filled out by each provider were evaluated. Only 54 providers have demonstrated an APL in using the partograph. Efforts still need to be made in properly using the partograph.

#	Description of indicators	Disaggregated by	FY14						Comments
			FY14 Target	Achieved Q1	Achieved Q2	Achieved Q3	Achieved Y3	Achievement rate for Y3	
	facilities funded by the US government								
10	Percentage of newborns who received a post-natal visit in the 3 days following birth		75%	ND	ND	ND	79%	104%	Based on the data collected in the SEDA, 41,122 newborns received a post-natal visit in the 3 days following birth out of an estimated target population of 52,049 live births for 2014.
11	Percentage of newborns receiving immediate neonatal care through a program supported by the US government		90%	ND	ND	ND	78%	87%	In the 20 districts where data has been collected through the SEDA, 40,835 newborns received immediate neonatal care out of an estimated target population of 52,049 live births for 2014.
12	Number of providers trained in child health and nutrition through a program supported by the US government	Altogether	2000	1032	1198	1579	2037	102%	Training of 458 new providers during the last quarter resulted in a 23% increase compared to the previous quarter.
		Men		503	563	685	816	--	
		Women		529	635	894	1221	--	
13	Number of service delivery		800	ND	ND	577	948	119%	Exhaustive data were collected from the medical regions to determine an

#	Description of indicators	Disaggregated by	FY14						Comments
			FY14 Target	Achieved Q1	Achieved Q2	Achieved Q3	Achieved Y3	Achievement rate for Y3	
	points assisted by USAID that have an established capacity to treat acute malnutrition								accurate baseline for this indicator. Initial results for all regions except Dakar, Louga, and Matam show that 948 SDPs have the established capacity to manage acute malnutrition.
14	Number of diarrhea cases among children under 5 treated with ORS/zinc through a program supported by the US government		45,640	ND	ND	ND	43,673	96%	This indicator was reported with SEDA data on 20 health districts. The target was set when use of ORS/zinc was still in the pilot stage. The indicator should be adjusted in the context of scaling up the use of ORS/zinc to treat diarrhea.
15	Number of children under 5 years with pneumonia receiving antibiotics recommended by qualified health workers as part of a program supported by the US government		37,981	ND	ND	ND	50,535	133%	This indicator was reported with SEDA data on 20 health districts. Targets for the indicator were greatly exceeded after collecting data in 20 districts. The indicator will be adjusted accordingly since the target was set in a context of data withholding.

#	Description of indicators	Disaggregated by	FY14						Comments
			FY14 Target	Achieved Q1	Achieved Q2	Achieved Q3	Achieved Y3	Achievement rate for Y3	
16	Number of malaria cases treated in programs supported by USAID (general population)		167,895	ND	ND	ND	51,371	31%	These data are from 20 districts in Senegal that have enrolled in SEDA. The data are from October 2013 to August 2014.
17	Number of providers trained in laboratory diagnosis of malaria (microscopy and RDT) through a program supported by the US government	Altogether	309	50	124	118	540	174%	Training of 248 additional providers, including company paramedical staff, has brought the number of providers trained in malaria to 540. This variance is because this year the component has primarily updated providers on the new national guidelines for malaria prevention and treatment for all providers. Training was held in Louga through the involvement of the MCR, who personally requested the component for support.
		Men		10	64	46	231	-	
		Women		40	60	72	309	-	
18	Number of providers trained in intermittent preventive therapy (IPT) through a program supported by the US government	Altogether	309	50	124	118	540	174%	
		Men		10	64	46	231	-	
		Women		40	60	72	309	-	
19	Number of providers trained in malaria management with ACT through a	Altogether	309	50	124	118	540	174%	
		Men		10	64	46	231	-	

#	Description of indicators	Disaggregated by	FY14						Comments
			FY14 Target	Achieved Q1	Achieved Q2	Achieved Q3	Achieved Y3	Achievement rate for Y3	
	program supported by the US government	Women		40	60	72	309	-	
Sub-component 2: Improved quality of health services in health posts, health centers, and regional hospitals									
20	Percentage of service delivery points assisted by USAID that experienced stockouts of contraceptive products, during the reporting period		20%	ND	50%	42%	16.8%	104%	This indicator was collected during supervision in a sample of 95 SDPs from across the country. Supervision indicated that only 16 SDPs had a stockout in contraceptive commodities during the 100 days prior to supervision. On-site supervision of providers and the IPM project seem to be the main factors helping to reduce the rate of contraceptives stockouts, for which performance is 104%.
21	Percentage of health facilities that received 1 or more supervision visits in the last 3 months		90%	13%	35%	50%	73%	81%	Supervision data show that 64 out of 88 SDPs received a supervision visit during the last 3 months. Despite a significant increase in performance over the last quarter, supervision still needs attention.
22	Number of supervision visits conducted by health facility staff members in community health services		1376	145	419	626	839	61%	During last quarter, 213 supervision visits to health huts were conducted in the regions of Saint Louis and Thiès. Data from other regions for the last quarter are not available yet.

#	Description of indicators	Disaggregated by	FY14						Comments
			FY14 Target	Achieved Q1	Achieved Q2	Achieved Q3	Achieved Y3	Achievement rate for Y3	
	sites (health huts and home care providers)								
23	Number of advanced strategies conducted by public health posts and health centers		3000	214	1152	1388	1945	65%	During the last quarter, the regions of Thiès and Saint Louis conducted 508 and 49 advanced strategies, respectively, implemented in health huts by ICPs. A total 557 advanced strategies for the last quarter brings the total number of advanced strategies for the year to 1945 and a performance rate of 65%. This low performance is due to delays in sending reports from other regions for the last quarter.
24	Number of local governments supported by the US government with an emergency transport system for pregnant women (SAMU)		112	83	83	88	88	79%	Activities to decentralize the SAMU continue in the Thiès region; however, new local governments were not served.
Sub-component 3: Improved human resources management in public sector health facilities									

#	Description of indicators	Disaggregated by	FY14						Comments
			FY14 Target	Achieved Q1	Achieved Q2	Achieved Q3	Achieved Y3	Achievement rate for Y3	
25	Number of SDPs with job descriptions for all positions		600	425	521	569	743	124%	During this quarter, 174 additional SDPs were able to established job descriptions for the various positions because of the work of tutors from the services management and organization package. This brings the number of SDPs with job descriptions to 743 and the annual performance rate to 124%.
Sub-component 4: Development of relationships with private sector health facilities									
26	Number of private facilities enrolled in TutoratPlus		64	ND	6	69	69	108%	This fiscal year, the situational analysis of SDPs in 21 districts resulted in the enrollment of 69 additional private facilities.

Annex 2: Summary of TutoratPlus implementation

Medical Region	Targeted districts	District enrolled	Estimated number of SDPs	# SDPs enrolled (SA+Action Plan)			# Tutors trained	# of newly enrolled SDPs*** in on-site supervision						SDP enrollment rate
				Public	Private	Total		Year 2	Q1 -Y3	Q2 -Y3	Q3 -Y3	Q4 -Y3	Total	
Louga	Darou Mousty	No	11	15	0	15								
	Kebemer*	No	19											
	Koki	Yes	11	11	0	11	5	0	5	0	0		5	45%
	Dahra	No	17	9	2	11	5	0	5	0	0		5	45%
	Linguère*	No	16											
	Sakal**	No	11											
	Keur Momar Sarr**	No	17											
	Louga**	No	16											
Dakar	Diamniadio	Yes	15	15	1	16	6	5	4	0	3		12	75%
	Rufisque	Yes	27	46	0	46	6	4	3	1	6		14	30%
	Pikine	Yes	18	11	9	20	6	0	6	0	6		12	60%
	Keur Massar	Yes	15	12	10	22	6	0	4	6	3		13	59%
	Mbao	Yes	20			25	6						0	0%
	Guédiawaye	Yes	21	14	9	23	6						0	0%
Diourbel	Diourbel	Yes	22	23	0	23	6	0	0	6	0		6	26%
	Touba	Yes	20	26	9	35	12	0	0	11	0		11	31%
	Bambey	Yes	24	28	0	28	6	0	0	5	0		5	18%
	Mbacké	Yes	19	21	1	22	6						0	0%
Fatick	Foundiougne	Yes	11	10	1	11	6	6	2	1	0		9	82%

Medical Region	Targeted districts	District enrolled	Estimate d number of SDPs	# SDPs enrolled (SA+Action Plan)			# Tutors trained	# of newly enrolled SDPs*** in on-site supervision						SDP enrollment rate
				Public	Private	Total		Year 2	Q1 -Y3	Q2 -Y3	Q3 -Y3	Q4 -Y3	Total	
	Passy	Yes	5	9	0	9	4	0	4	3	0		7	78%
	Gossas	Yes	11	8	4	12	5	0	0	9	0		9	75%
	Fatick	Yes	25	27	3	30	5	0	5	2	3		10	33%
	Sokone	Yes	17	15	5	20	6						0	0%
	Niakhar	Yes	7	7	1	8	5						0	0%
	Diofior	Yes	14	13	3	16	5						0	0%
Sédhiou	Goudomp	Yes	12	15	1	16	5	7	0	2	0		9	56%
	Boukiling	Yes	17	20	0	20	6	0	0	0	6		6	30%
	Sédhiou	Yes	14	16	0	16	6						0	0%
Kaolack	Kaolack	Yes	61	34	28	62	13	27	0	0	0		27	44%
	Ndoffane	Yes	21	12	6	18	6	0	11	4	1		16	89%
	Guinguinéo	Yes	12	13	1	14	5	0	4	8	0		12	86%
	Nioro	Yes	29	26	6	32	8						0	0%
Tambacounda	Kidira	Yes	13	14	2	16	1	4	0	1	0		5	31%
	Goudiry	Yes	11	12	2	14	1	0	0	0	0		0	0%
	Koumpentoum	Yes	10	10	2	12	1						0	0%
Kolda	Kolda	Yes	23	26	8	34	7	5	0	5	0		10	29%
	Medina Yoro Foulah	Yes	10	10	0	10	6	0	0	5	2		7	70%
	Vélingara	Yes	19	20	4	24	8						0	0%
Kaffrine	Koungheul	Yes	19	17	2	19	5	8	2	4	1		15	79%

Medical Region	Targeted districts	District enrolled	Estimate d number of SDPs	# SDPs enrolled (SA+Action Plan)			# Tutors trained	# of newly enrolled SDPs*** in on-site supervision						SDP enrollment rate
				Public	Private	Total		Year 2	Q1 -Y3	Q2 -Y3	Q3 -Y3	Q4 -Y3	Total	
	Malem Hoddar	Yes	9	17	0	17	5	0	5	5	1		11	65%
	Birkilane	Yes	6	14	0	14	5	4	6	1	2		13	93%
	Kaffrine	Yes	25	21	2	23	6						0	0%
Matam	Matam	Yes	10	11	0	11	1	0	0	0	0		0	0%
	Thilogne	Yes	10	10	0	10	1	0	0	0	0		0	0%
	Ranérrou	Yes	10	13		13	1						0	0%
Saint-Louis	Podor	Yes	34	35	1	36	8	16	1	0	7		24	67%
	Saint Louis	Yes	18	21	4	25	8	0	8	8	0		16	64%
	Dagana	Yes	17	14	2	16	5	0	4	1	3		8	50%
	Pete	Yes	27	26	1	27	8						0	0%
	Richard Toll	Yes	29	22	1	23	8						0	0%
Kédougou	Saraya	Yes	12	12	0	12	5	1	0	0	0		1	8%
	Kédougou	Yes	10	10	0	10	4	0	1	1	0		2	20%
	Salémata	Yes	8	7	0	7	4						0	0%
Thiès	Thiès	Yes	68	32	24	56	12	10	3	9	7		29	52%
	Popenguine	Yes	12	10	2	12	5	0	8	3	1		12	100%
	Joal Fadiouth	Yes	9	7	3	10	4	0	5	2	1		8	80%
	Thiadiaye	Yes	12	10	2	12	5	0	5	4	0		9	75%
	Mbour	Yes	34	22	12	34	6	0	6	4	5		15	44%
	Tivaouane	Yes	37	23	0	23	8						0	0%
	Pout	Yes	10	9	0	9	5						0	0%

Medical Region	Targeted districts	District enrolled	Estimate d number of SDPs	# SDPs enrolled (SA+Action Plan)			# Tutors trained	# of newly enrolled SDPs*** in on-site supervision						SDP enrollment rate
				Public	Private	Total		Year 2	Q1 -Y3	Q2 -Y3	Q3 -Y3	Q4 -Y3	Total	
Ziguinchor	Khombole	Yes	17	16	0	16	5						0	0%
	Mékhé	Yes	14	19	0	19	4						0	0%
	Ziguinchor	Yes	30	22	6	28	7	9	3	6	6		24	86%
	Bignona	Yes	31	28	2	30	8	0	8	8	5		21	70%
	Diouloulou	Yes	19	18	1	19	4	0	4	4	0		8	42%
	Oussouye	Yes	16	13	2	15	6						0	0%
	Thionck-Essyl	Yes	17	14	1	15	6						0	0%
1st Gen. Total	15	15	368	327	74	401	88	102	18	35	30	0	185	46%
2nd Gen. Total	28	26	439	389	74	463	138	4	104	94	39	0	241	52%
3rd Gen. Total	24	18	424	325	38	388	118	0	0	0	0	0	0	0%
Total Y1+Y2+Y3	67	60	1231	1041	186	1252	344	106	122	129	69	0	426	34%

* The SA was suspended in these two districts due to the boycott of activities by providers.

** In the end, these districts did not enroll due to the boycott by providers, which led to transferring activities to the Kédougou region.

Annex 3: Summary of IPQS training

IPQS areas	Regions	Objectives for Year 3	Number of individuals trained			Achievement rate	Number of SDPs affected				
			M	W	Total		Health centers	Health posts	Hospitals	Private and semi-public SDPs	Total
Training for providers on focused ANC	Thiès, Sédhiou, Saint Louis, Kaolack, Dakar	183	356	704	1060	579%	67	755	13	46	881
Diagnosis and case management of malaria	Louga, Sédhiou, Kolda	309	208	301	509	165%	16	225	5	49	295
Support for EPI training for providers	Thiès, Sédhiou, Saint Louis, Louga, Fatick, Matam, Tambacounda	500	499	519	1018	204%	52	698	3	50	803
Training of providers on long-term and permanent methods (Support for regional FP plans)	Kolda	-	20	67	87	-	5	59	1	18	83
Training for providers on nutrition applied to the life cycle	Thiès, Sédhiou, Saint Louis, Fatick, Ziguinchor, Diourbel	150	200	402	602	401%	62	423	37	26	548

IPQS areas	Regions	Objectives for Year 3	Number of individuals trained			Achievement rate	Number of SDPs affected				
			M	W	Total		Health centers	Health posts	Hospitals	Private and semi-public SDPs	Total
MAM training	Kaolack, Dakar	160	144	259	403	252%	20	225	7	19	271
Training for providers on PAC	Kolda, Sédhiou, Fatick, Diourbel	45	12	81	93	207%	30	7	11	1	49
Management of FP file (support for regional FP plans)	Saint Louis	-	17	40	57	-	2	40	0	1	43
Dissemination of new guidelines for treating malaria (orientation for providers)	14 regions	-	294	483	777	-	51	413	6	37	507
Training for providers in IMCI	Thiès, Kaolack, Fatick, Kaffrine, Diourbel	-	82	88	170	-	26	119	9	2	156
Creation of a pool of trainers for clinical IMCI	Kaffrine	-	5	1	6	-	0	3	1	0	4
Training for providers in the management of diarrhea with ORS/zinc (Support for Child Survival Plan)	Dakar	-	59	188	247	-	8	66	0	29	103

IPQS areas	Regions	Objectives for Year 3	Number of individuals trained			Achievement rate	Number of SDPs affected				
			M	W	Total		Health centers	Health posts	Hospitals	Private and semi- public SDPs	Total
Training for providers on EmONC	Sédhiou, Ziguinchor	82	19	50	69	84%	28	0	2	1	31

Annex 4: Integration of FP and vaccination

Medical Region	# of sessions held	# People reached			# FP users by method					Enrollment rate
		Men	Women	Total	Oral contraceptives	Injectables	Implants	IUD	TOTAL	
Dakar	39	105	1218	1323	112	211	53	19	395	32%
Kaffrine	192	0	6348	6348	170	810	567	53	1600	25%
Kaolack	155	0	3152	3152	380	756	278	89	1531	49%
Kolda	75	388	4749	5137	174	1222	92	3	1491	31%
Saint Louis	351	8	9736	9744	1218	2372	328	83	4001	41%
Sédhiou	198	1046	1405	2451	175	209	64	2	450	32%
Thiès	82	950	1496	2446	286	507	140	50	983	66%
Ziguinchor	14	25	459	484	39	35	23	2	99	22%
Fatick	54	5	1970	1975	58	148	160	17	383	19%
TOTAL	1160	2527	30,533	33,060	2612	6270	1705	318	10,933	36%

Annex 5: Summary of results of implementation of integrated advanced strategies

Region	Number of advanced strategy visits	Number of huts supervised	Children's health			ANC				PNC			New FP users
			Children immunized	Children who received Vitamin A	ITNs distributed	ANC VISITS 1–4	IPT under DOT 1–3	Tetanus vaccine 1–3	ITNs distributed	D1–D3	D4–D15	D16–D42	
Dakar	19	13	351	135	0	152	56	5	3	15	27	16	87
Diourbel*	0	0	0	0	0	0	0	0	0	0	0	0	0
Fatick	9	9	365	2	0	38	33	16	1	5	10	5	22
Kaffrine	52	24	2275	858	44	370	237	5	64	45	74	45	180
Kaolack*	78	78	3760	193	158	1001	686	572	46	110	149	115	327
Kédougou	40	15	2003	0	0	331	83	206	0	42	76	5	148
Kolda*	311	0	9651	709	19	3658	2389	1266	920	353	432	365	1840
Louga	311	304	2031	2760	518	1232	868	696	640	214	329	343	1452
Matam	6	6	180	0	0	86	43	26	0	0	0	0	16

Region	Number of advanced strategy visits	Number of huts supervised	Children's health			ANC				PNC			New FP users
			Children immunized	Children who received Vitamin A	ITNs distributed	ANC VISITS 1–4	IPT under DOT 1–3	Tetanus vaccine 1–3	ITNs distributed	D1–D3	D4–D15	D16–D42	
Saint Louis	157	100	2132	316	29	278	164	45	63	23	74	56	370
Sédhiou*	0	0	0	0	0	0	0	0	0	0	0	0	0
Tambacounda	42	42	3121	0	0	432	121	101	0	81	111	35	298
Thiès*	836	164	20,390	2260	2445	5115	3244	1954	2488	698	909	739	1613
Ziguinchor*	84	84	1051	1769	9	398	280	0	18	70	67	51	150
Total	1945	839	47,310	9002	3222	13,091	8204	4892	4243	1656	2258	1775	6503

Annex 6: Initiative to eradicate stockouts of essential medicines and commodities in Nioro

INTRODUCTION

During Year 3 of the project, the component launched an approach to improve the availability of essential tracer drugs in the SDPs of Nioro health district. This approach includes several steps:

- The development, sharing, and validation of a rubric to assess the causes of stockouts with the MCD and district pharmacy focal point
- Orientation for Nioro ECD members
- Assessment of drug stockouts for 25 SDPs in the district
- Sharing results with district stakeholders (ECD, ICP, distributors, and health committee presidents) and development by each SDP of a plan to resolve identified gaps
- Training for ICPs who must regularly supervise their distributors
- Training/retraining for distributors
- Post-training follow-up of ICPs and distributors in stock management, first by the ECD alone and then with PRA and IntraHealth support
- The development, sharing, and validation of a monthly report template for drug stock management able to produce indicators for stockouts, expiration, and order efficiency

RESULTS

The first evaluation of the approach showed a significant increase in the availability of essential tracer drugs that are monitored. Availability measures the amount of time the drug is available; therefore, it is the ratio of the time when the drug is available over the total length of the period.

- Percentage of accurate reporting on forms: only 4 of the 26 SDPs had a percentage greater than or equal to 80%, compared to 11 in 2014. In 2014, 11 of the 26 distributors reported an accurate percentage for stock sheets greater than or equal to 80%, compared to only 4 distributors in 2013.
- Availability of essential tracer drugs:
 - 24/26 SDPs had an availability rate greater than or equal to 80% for both 2013 and 2014
 - 21/26 SDPs had an availability rate greater than or equal to 84% in 2013, compared to 23 SDPs in 2014. We selected 80% as the minimum performance required, and outcomes were identical in 2013 and 2014
 - 7/26 SDPs had a percentage for average stockout time below 11%, compared to 10 in 2014
- 100% availability for contraceptives in all SDPs in 2014
- 100% availability for ACT in all SDPs in 2014

THE WAY FORWARD

- Sharing monthly reports on the management of essential tracer drugs
- More regular supervisions of SDPs by the ICPs and ECD
- Implementation of an early warning system for stockouts through the SEDA

Annex 7: Case study

Case study – Médina Daffé health post: TutoratPlus outcomes on MNCH-PF services

The situational analysis conducted in 2013 showed that the integrated services package was not available in the Medina Daffé health post. The health post had just been set up instead of a health hut, and an assistant nurse was recently appointed there.

The table below shows the availability of MNCH services at the time of the situational analysis.

Table 1: Availability of services

Services	Available	Provider performance level
ANC	Yes	20%
Parto	No	NA
AMTSL	No	NA
PNC	Yes	50%
ENC	No	NA
FP	No	NA

The main reasons that MNCH/FP services were unavailable are lack of equipment and lack of provider training.

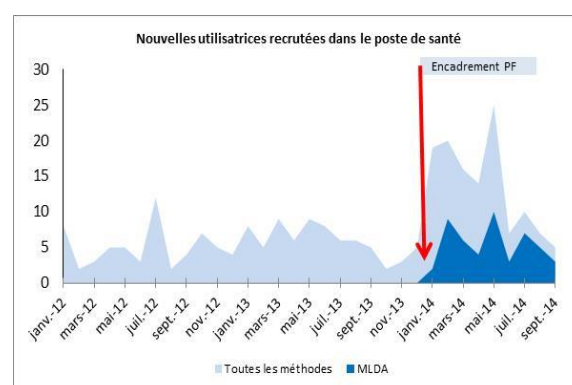
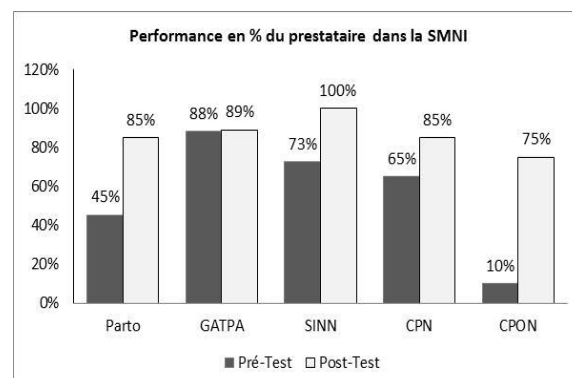
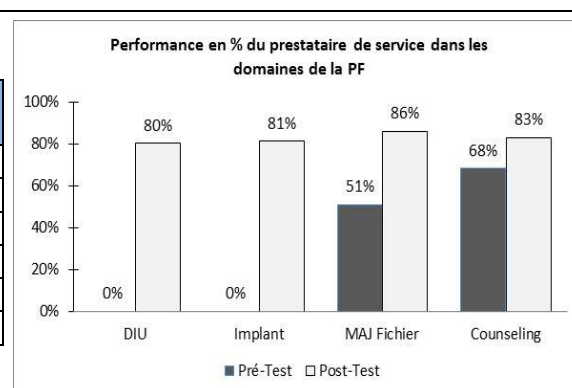
Deliveries are performed there; however, the partograph was not used. For family planning, the nurse does not deliver long-term methods.

INTERVENTION:

TutoratPlus is a training approach using on-site supervision. On-site supervision addresses six services packages, notably MNCH, FP, Disease Control, ISM, Organization and Management of Services, and Health Promotion. In January 2014, a provider received a visit from two tutors for packages 1 and 2. For package 1, the provider was coached in ANC and monitoring labor with the partograph, AMTSL, immediate care, and PNC; for the FP package, the provider was coached on counseling (including initial counseling for two matrons), long-term methods (IUD and Jadelle) as well as the ISM.

Figures 1 and 2 show the change in provider performance in MNCH/PF services delivery before and after on-site supervision by tutors.

The third figure shows the increase in new users of an FP method when long-term and permanent methods were first offered in January 2014, the date of on-site supervision for FP.



“Thanks to TutoratPlus, the health post has a much broader range of services.”

Annex 8: Success story



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SUCCESS STORY

TutoratPlus Helps a Community to Breathe New Life into their Health Post

The TutoratPlus approach works with providers and clients to expand services and improve the health of women and children



Photo Caption: With the assistance of TutoratPlus, the Jean Louis Beaumon health post has successfully brought providers, and health committee members together to improve services and respond to client needs.

Photo: Carol Cissé, IntraHealth

"Now, instead of a *matron* (community health worker), the health post has a [trained] midwife who is available at any time. She even has cooking demonstrations to help our children. I think the staff deserves to be supported in order to continue improving the health post" says client Saly Diané.

Telling Our Story

U.S. Agency for International Development
Washington, DC 20523-1000
<http://stories.usaid.gov>

The Jean Louis Beaumon health post is like many others in Senegal. It is a community health facility that offers neighboring households a variety of low-cost services such as childhood vaccinations, prenatal and postnatal check-ups, child nutritional monitoring, a pharmacy, and general medical care. A year ago, however, this health post was in trouble. It suffered from a lack of qualified staff, dilapidated facilities, broken equipment, and an uninviting atmosphere. "Before, women didn't want to go to the health post because the post didn't have medicine and the provider wasn't always available," says client Saly Diané.

IntraHealth International's USAID-funded Health Services Improvement (HSI) project is helping to improve the quality of provider- and facility-level service delivery through the introduction of TutoratPlus, a site-based performance improvement process. TutoratPlus directly engages and supports providers to identify gaps in job performance and improve the care they deliver by addressing factors that can influence the quality, availability, and use of health services. Mentors work with providers to draft action plans, and provide regular supervision and additional training as needed. Before TutoratPlus's introduction, Jean Louis Beaumon had no staff housing, recordkeeping was outdated, the facility pharmacy didn't track and monitor medicines, and there was no cost recovery mechanism or funding to pay for utilities.

As a result of participating in the TutoratPlus approach, the health post has undergone dramatic changes. For the past year, TutoratPlus mentors have worked with health post providers and health committee members to identify the facility's most pressing problems, create an action plan to address them, and pinpoint funding sources to pay for improvements. Importantly, the health post has renovated two existing buildings to provide housing to the chief nurse and midwife, which has improved response rates and enabled providers to be available 24 hours a day. Mentors trained facility providers on how to update health

records, registers, and filing systems—now, health data are reported accurately on a monthly basis. The post’s health committee has financed the refurbishment of an on-site laboratory, which has increased the number of women who can get lab tests and results at the health post rather than at the local hospital. Finally, mentors and the health post secured funds from the local municipal government to pay for the facility’s electricity and water, salaries of two security guards, trash disposal, and a cleaning woman.

Jean Louis Beaumon now exudes a warm, welcoming, and clean atmosphere. Health post personnel are competent and skillful—providing community cooking classes, actively promoting vaccinations for pregnant women and children, offering skilled birth attendants, and providing general medical services. The facility’s data show the impact of the improvements. General consultations have increased by 20% since the TutoratPlus changes were implemented, prenatal care is provided to 30% more women, unattended home births have become non-existent, and orders of essential medicines are now recorded correctly. TutoratPlus mentors continue to engage health post staff to improve the facility’s services and increase the community’s access to quality health services. Saly shares this sentiment: “Now, instead of a *matron* (community health worker), the health post has a [trained] midwife who is available at any time. She even has cooking demonstrations to help our children. I think the staff deserves to be supported in order to continue improving the health post.”



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SUCCESS STORY

TutoratPlus Improves Client Access to Long Acting Contraceptive Methods

The *TutoratPlus* approach has improved women's access to, and use of, long acting contraceptive methods in Ziguinchor



Photo Caption: The Bon Samaritan Catholic Health Post can now offer a full range of options to any woman who wants to practice family planning

Photo: Carol Cissé, IntraHealth

"Demand for FP has increased, which can be seen in the consultation register. More clients are coming and requesting long-acting methods," says Ms. Navi Sossa, Midwife at the Good Samaritan Health Post

Telling Our Story

U.S. Agency for International Development
Washington, DC 20523-1000
<http://stories.usaid.gov>

At the Good Samaritan health post in Senegal's southern region of Ziguinchor, midwife Navi Sossa has been able to provide expanded family planning (FP) services to her clients thanks to IntraHealth International's TutoratPlus on-site mentoring and training approach. "When I started at this health facility, FP services were limited and only offered to married women. This is due to the fact that the Good Samaritan is a Catholic health facility. As the only midwife in the facility, the FP services I could offer were very limited," says Navi.

At first, the health post only allowed Navi to promote "natural" FP methods such as exclusive breastfeeding and withdrawal or short acting methods such as condoms and pills. With the help of local TutoratPlus peer mentors, however, Navi received training on the full range of long- and short-acting contraceptive methods, as well as management of side effects, systematic screening for method eligibility, counseling skills, and service delivery. Navi observes, "Previously, I didn't have the skills or tools to help women have access to long-acting methods." Post-training, Navi is able to competently offer her clients an expanded range of methods such as implants, injectables, and IUDs. She says, "Demand for FP has increased, which can be seen in the consultation register. More clients are coming and requesting long-acting methods."

With her reinforced knowledge and skills, Navi felt confident enough to petition the senior health post administrator to extend FP services to all women at the clinic who want them, regardless of their marital status. After many discussions, the health post agreed to offer FP services to all women.

Navi firmly believes that the TutoratPlus approach of using peer mentors and on-site training and supervision is the best way to improve access to quality health services. TutoratPlus has also had a broader impact on the way that Navi and other Good Samaritan staff think about infection prevention and environmental protection. After just one round of supervision by her mentor, Navi noted a change in the way she worked. She started to make sure that her consultation room was inviting to clients before counseling sessions, while consistently adopting proper waste disposal techniques and correct infection prevention methods such as hand washing before examinations or injections. "Now, I have a proper way to dispose of waste instead of it being thrown behind the clinic," Navi says. "I am

also practicing good risk reduction by having a sharps container for needles. This reduces risk to me as well as my clients.”

Navi adds, “Thanks to the on-site coaching and supervision, I have seen improvements in not only my own interactions with clients but the overall happiness of the clinic staff. Clients come because they know they will receive quality health services in a clean and safe environment. Women recognize that I am knowledgeable and can give them options to plan their families in a pleasant and confidential manner.”